BOPHELO

MINISTRY OF HEALTH

Assessment to Promote Mental Health Care and Wellbeing in Lesotho

LESOTHO-BOSTON HEALTH ALLIANCE

BOSTON MEDICAL CENTER

Assessment to Promote Mental Health Care and Wellbeing in Lesotho

Collaborating Institutions

- Lesotho Ministry of Health
- Lesotho-Boston Health Alliance
- Boston University Wheelock Institute for Early Childhood Well-being
- Boston Medical Center

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LIST OF ACRONYMS

CDC Africa	Africa Centers for Disease Control
BMC	Boston Medical Center
BU	Boston University
CBO	Community-Based organization
CHAL	Christian Health Association of Lesotho
DHMT	District Health Management Team
HCW	Health Care Worker
HIC	High-Income Country
IECW	Institute for Early Childhood Well-Being
LeBoHA	Lesotho-Boston Health Alliance
LMIC	Low-and-Middle-Income Countries
MHW	Mental Health Worker
MOH	Ministry of Health
NUL	National University of Lesotho
THP	Traditional Health Practitioner
UN	United Nations
VHW	Village Health Worker
WHO	World Health Organization

EXECUTIVE SUMMARY

Mental health is increasingly recognized as critical to holistic wellbeing, and as impacting and impacted by physical health. Globally, evidence suggests increasing levels of mental distress with low- and middle-income countries (LMICs) bearing a higher burden with fewer resources than high-income countries (HICs), resulting in greater treatment gaps. This is true in Lesotho as well, as limited data suggest rates of common mental disorders of around 20%, with high rates of substance use, self-harm, and suicide. Additionally, Lesotho's mental health expenditure is low and its mental health workforce is limited.

Mental distress affects quality of life, morbidity, and mortality. Physical and mental comorbidities are common, and common mental disorders are among the leading burden of diseases in Lesotho. Mortality is also significantly higher amongst people with mental disorders compared with the general population. Apart from the effect on the individual, mental health challenges affect interpersonal relationships, family dynamics, and community wellbeing across economic, social, and political sectors.

A lack of data related to mental health and mental health systems and services prevents an understanding of what illnesses are most prevalent, where challenges lie, and how to prioritize funding to improve care and promote wellbeing. This report helps fill the gaps. Health workers, mental health workers, and community members were invited to participate in focus groups to discuss mental health and mental health care in Lesotho. Major findings are presented below, in three sections: the ability to recognize signs and symptoms of mental distress across the lifespan, challenges affecting mental health in Lesotho, and solutions to improve mental health and care in Lesotho.

Recognizing signs and symptoms of mental distress across the lifespan

- Participants were able to recognize many signs and symptoms associated with mental distress, but less so in very early childhood and older adults. Mental health in very early childhood, early childhood, adolescence, and older people is particularly under-recognized, limiting early recognition of mental health challenges and access to mental health care.
- Common misconceptions of behavior that could indicate mental distress are that a child is just seeking attention or being naughty, or that an older adult is performing witchcraft.

Challenges affecting mental health in Lesotho

- Social determinants of mental health exist at individual, interpersonal, community, and national levels, and should be targeted as part of initiatives to improve mental health.
- Social determinants of mental health in Lesotho include economic stability (unemployment, poverty, and wealth disparity), access to education and school absenteeism in children, relationship quality (family and inter-partner conflict and positive parenting), violence (gender-based violence, intimate partner violence, violence against children, community violence, and bullying), communication (misinformation

from social media and other sources), stigma, and a lack of prioritization of mental health by the government. These factors significantly impact mental health across the lifespan Lesotho.

Solutions to improve mental health and care in Lesotho

- More education is needed across the lifespan of signs and symptoms of mental health disorders. Education should be tiered and tailored to different populations including: general education on mental health across the lifespan for community members; integration of mental health literacy and coping strategies into life skills training in schools; training teachers, traditional health practitioners, community leaders and lay/HIV Testing and Counseling (HTC) counselors to recognize signs and symptoms of mental distress, and how to refer individuals experiencing distress; and mental health education and integration into primary health care.
- Mental health care and promotion should begin prenatally to support optimal development and subjective wellbeing throughout the lifespan.
- Mental health care and promotion involves not just individuals, but also families, communities, and national policy. Healthcare provision should therefore address these different levels through combined person-centered, family-centered, and community-based initiatives directed through an updated national mental health policy.
- Diverse initiatives across levels of care are needed that not only target mental illness treatment, but also prevention and early interventions of illness and promotion of wellbeing. These initiatives need not target a single identified challenge but can be multimodal. For example, an initiative could seek to address positive parenting, parent and child mental health, and family economic empowerment to improve the wellbeing of individuals within families. Another could target mental health stigma in communities and health providers through psychoeducation and engagement with people with lived experiences.
- Asset-mapping should be conducted to identify existing community-based resources, including community members' expertise and community strengths, which can be paired with evidence-based initiatives and government support, to provide sustainable and expanded care. Initiatives should involve participatory approaches that take into account the priorities, values, and ideas outlined by communities and individuals receiving services.
- Stigma should be addressed through education and myth-busting. Boys and men should be engaged in particular, as they are less likely to seek care. In addition to stigma related to mental health, stigma towards people with disabilities and people identifying as LGBTQI+ should be addressed.

- Universal initiatives such as mental health literacy should be provided to all community members in meaningful and developmentally and contextually appropriate ways. Examples could include community gatherings for adults and older adults, near peer education and participatory approaches for adolescents and youth, and mental health integration into life skills programs at schools.
- Tiered prevention and early interventions initiatives should include family systems support from social workers, VHWs, or other leaders trained in basic mental health provision, and increased monitoring and mental health supports for vulnerable populations including older adults and at-risk children and youth.
- Interventions for mild-to-moderate mental distress should be available at health centers or district hospitals, which should be capacitated with trained mental health counselors who can integrate mental health into primary health care. Patients should have access to ongoing treatment – medication and psychotherapy – locally.
- Expansion of the provision of mental health care to families, communities, and group therapy could expand access through the treatment of multiple people at a time.
- Inpatient mental health care should be made available at district hospitals.
- Mohlomi Hospital should be renovated to provide safe, humane facilities and to improve patient care and wellbeing and staffed with trained psychiatrists, counselors and staff.
- A rehabilitation center is needed to provide specialized support for substance misuse.
- Community-based recovery services should be improved by capacitating VHWs and improving communication between VHWs, health centers, and district hospitals.
- Procedures and guidelines for up-and-down referrals should be clarified, to ensure that patients are receiving timely access to services. Communication should be improved across levels of care.
- To provide ongoing mental health care across levels of service, additional mental health practitioners should be hired or trained, including: village health workers with training in mental health care; mental health counselors at health centers and district hospitals; a clinical psychologist available at each district hospital in the country; three psychiatrists dedicated to Mohlomi Hospital, the northern region of the country, and the southern region of the country; and child, geriatric, and forensic specialists. School counselors should also be dedicated communities in Lesotho, to identify school children in need of care, to provide basic care, and to provide referrals.
- Opportunities for continuing education and professional development should be provided to further capacitate the mental health workforce. These opportunities should include the development of in-country training programs such as an MMed psychiatry program. A minimum of two psychiatrists must be hired for the program to start.

Additionally, psychology and master's programs for psychiatric-mental health nursing should be initiated. Short courses should be developed that are relevant to health care professionals at different levels of care, to increase awareness of mental health promotion, prevention, treatment, and recovery and to better integrate mental health into primary health care across levels of care.

- The Ministry of Health should clarify mental health policy and guidelines to be followed by mental health practitioners and researchers. This should include professional licensing for counselors and psychologists
- National clinical mental health guidelines should be updated and approved by the Ministry of Health within the next two years.
- Communication and networking should be improved across governmental and non-governmental sectors. As mental health is impacted not just by medical considerations but also social, economic, educational, and political factors, opportunities should be explored for greater collaboration between Ministries of Health, Education, Justice, Gender, and Social Development, amongst others, as well as between government and NGOs.
- Cross-sector initiatives should be developed to address challenges such as violence against children and gender-based violence. These initiatives should include the voices of all genders.
- Education should be provided to all children from pre-primary school through high school, to provide young people with educational opportunities and decrease risk.
- Employment opportunities should be expanded for young people and adults, including apprenticeships, internships, and microlending to support self-employment or small business opportunities.
- Data collection and monitoring for mental health diagnoses and treatment should be ongoing, to better direct allocation of funding. Additionally, research should be encouraged, to better understand and improve mental health and mental health care in Lesotho.

The people of Lesotho are facing many challenges that are affecting mental health and quality of life, but solutions are available. The list of recommendations above is long but feasible, particularly with government support, collaboration across sectors, and public-private engagement. The time to act is now.

SECTION 1: INTRODUCTION AND BACKGROUND

The burden of mental illness is high and rising. The World Health Organization estimates 13% of people worldwide are living with a mental disorder[1], which has created an increasing gap between need and access to mental healthcare services that is particularly large in low- and middle-income countries (LMICs)[2,3]. Additionally, the COVID-19 pandemic resulted in increased reporting of major depressive disorders and anxiety without concurrent increases in mental health resources, further widening the treatment gap[4]. Further causes of mental illness in LMICs include sociodemographic factors such as poverty and chronic disease such as HIV/AIDS[5]. In Lesotho, a LMIC with a population of 2.2 million, a 36% poverty rate[6] , and an estimated 290,000 people living with HIV[7], these comorbidities have been found to be associated with poor mental health and substance misuse[8,9]. In fact, 2016 study found that one-fifth of Lesotho's population suffer from mental illness[10], and Lesotho's suicide rate is one of the highest globally, at 72.4 per 100,000[11]. The estimated disability-adjusted life years (DALYs) per 100,000 in the country is 2,977[12].

In addition to the high burden of mental illness, Lesotho suffers from a dearth of mental health services and professionals. Mental health expenditures in the country remain low, inpatient and outpatient care is limited to a small number of facilities, and there are an estimated 13.7 mental health workers for every 100,000 people in the country; this number includes fewer than one psychiatrist or psychologist for every 100,000 people[12]. These numbers suggest a wide treatment gap that places a disproportionate burden on Basotho and highlight the necessity of prioritizing mental health in promoting individual wellbeing. Evidence-based,

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[1] WHO. Mental Disorders [Internet]. World Health Organization. 2022. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-disorders

[2] WHO mental health gap action programme (mhGAP) intervention guide: updated systematic review on evidence and impact

[3] Qin X, Hsieh CR. Understanding and addressing the treatment gap in mental healthcare: economic perspectives and evidence from China. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. 2020 Sep;57:0046958020950566.

[4] Santomauro DF, Herrera AM, Shadid J, Zheng P, Ashbaugh C, Pigott DM, Abbafati C, Adolph C, Amlag JO, Aravkin AY, Bang-Jensen BL. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. The Lancet. 2021 Nov 6;398(10312):1700-12.

[5] Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, Chisholm D, Collins PY, Cooper JL, Eaton J, Herrman H. The Lancet Commission on global mental health and sustainable development. The lancet. 2018 Oct 27;392(10157):1553-98.

[6] Lesotho [Internet]. World Bank. Available from: https://www.worldbank.org/en/country/lesotho

[7] Lesotho [Internet]. Unaids.org. 2016. Available from: https://www.unaids.org/en/regionscountries/countries/lesotho

[8] Hayes-Larson E, Hirsch-Moverman Y, Saito S, Frederix K, Pitt B, Maama-Maime L, Howard AA. Depressive symptoms and hazardous/harmful alcohol use are prevalent and correlate with stigma among TB-HIV patients in Lesotho. The International Journal of Tuberculosis and Lung Disease. 2017 Nov 1;21(11):S34-41.

[9] Mofokeng S, Green S. Exploring the views of health care service providers on life stressors and basic needs of HIV-positive mothers in rural areas of Lesotho. Social Work/Maatskaplike Werk. 2017;53(1):45-56.

[10] Treating Mind and Body: Mental Health Care Expanding in Lesotho [Internet]. Partners In Health. Available from: https://www.pih.org/article/treating-mind-and-body-mental-health-care-expanding-lesotho

[11] World Health Organization. Suicide rates [Internet]. www.who.int. 2023. Available from: https://www.who.int/data/gho/data/themes/mental-health/suicide-rates

[12] Mental Health Atlas 2014 Country Profile: Lesotho [Internet]. Who.int. 2025 [cited 2025 Jan 6]. Available from: https://www.who.int/publications/m/item/mental-health-atlas-2014-country-profile-lesotho

sustainable, and culturally relevant strategies are needed to raise awareness that mental health is critical to wellbeing and to address the high burden of mental health conditions and the low availability of care. Before these strategies can be developed, a comprehensive understanding of perceptions of mental health and mental illness in the country should be obtained, as well as a thorough understanding of the current mental health infrastructure, mental health care accessibility and acceptability, the perceived needs of the population, and gaps in treatment.

1.1 Problem statement

Despite high rates of mental illness, Lesotho has limited mental health care infrastructure. As a precursor to redressing this imbalance, a comprehensive understanding of the current infrastructure, resources, barriers to access, and gaps is needed. The proposed study will analyze exploratory qualitative focus groups to better understand local conceptualizations of mental health and mental illness, elucidate available mental health resources, determine gaps in mental healthcare, and develop recommendations for improving mental health care and mental health care provision in Lesotho.

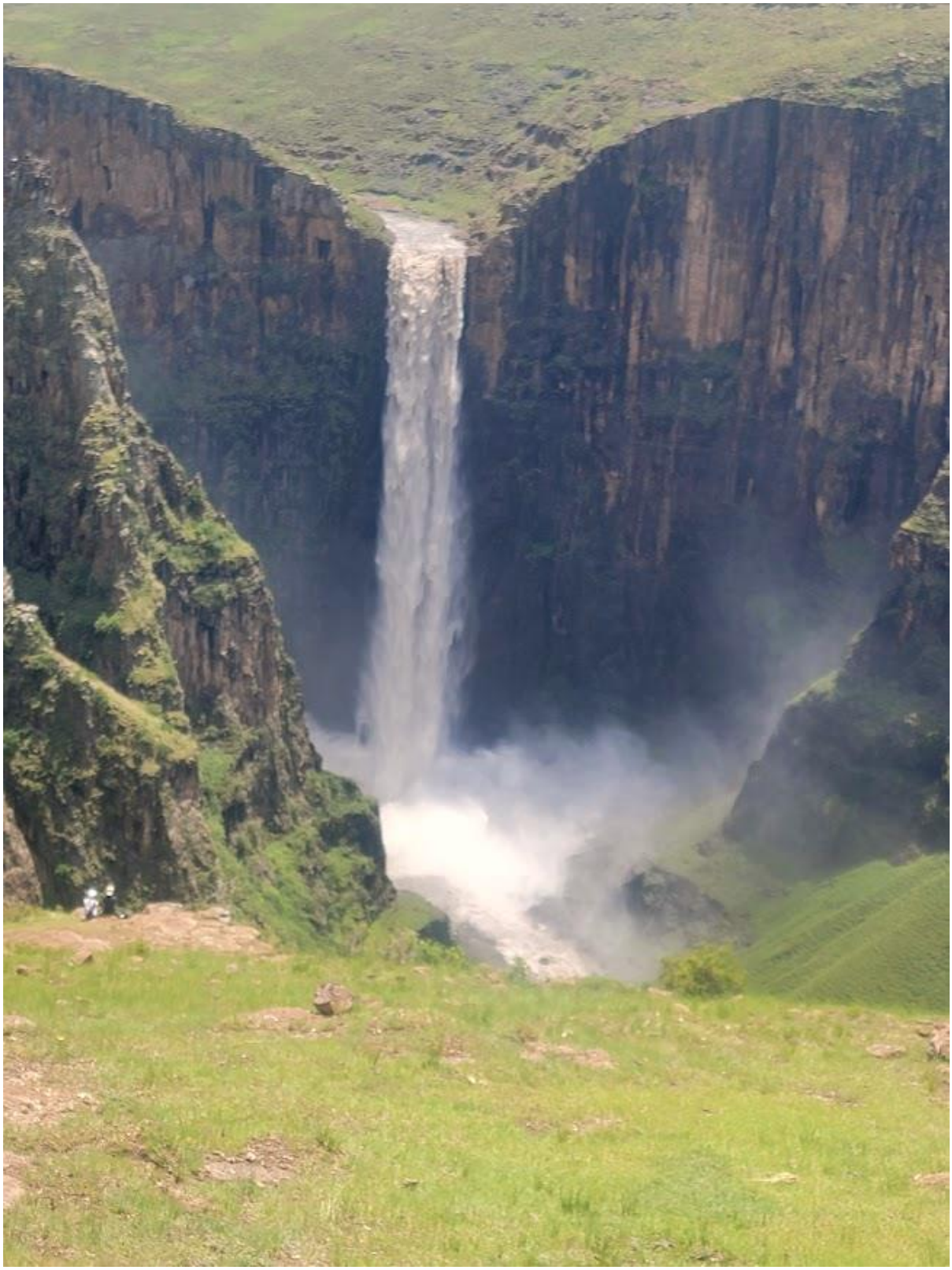
1.2 Study aim

This study aims to fill the gap in our understanding of mental health and mental health care provision in Lesotho, through a situational analysis of mental healthcare infrastructure and a needs assessment of mental health care providers, health care providers, and the general population.

1.3 Research questions

- How do health and wellbeing professionals in Lesotho define mental health and mental illness?
- How do members of the broader community in Lesotho define mental health and mental illness?
- According to mental health care providers, health care providers, and the general public of Lesotho, what resources are available to individuals experiencing mental health crises?
- According to mental health care providers, health care providers, and the general public of Lesotho, where are the gaps and limitations in the provision of mental health care?
- According to mental healthcare providers, health care providers, and the general public of Lesotho, what are recommendations for improving mental health, access to mental health, and mental health services in Lesotho?

SECTION 2: METHODS



INTRODUCTION

The purpose of this needs assessment and situational analysis is to fill the gap in understanding of mental health and mental health care provision across the lifespan in Lesotho. To achieve this aim, participants were asked to address the following topics:

- How do health and wellbeing professionals in Lesotho define mental wellbeing and mental illness, for children, adolescents, adults, and older people?
- How do members of the broader community in Lesotho define mental wellbeing and mental illness, for children, adolescents, adults, and older people?
- According to health and mental health professionals and community members, what resources are available to support the development and maintenance of wellbeing, and to intervene in crises?
- According to health and mental health professionals and community members, what are the gaps and limitations in the provision of mental health care?
- According to health and mental health professionals and community members, what are recommendations for improving mental health, access to mental health, and mental health services in Lesotho?

2.1 Study design and sampling

Focus groups were used to elicit participant responses to the topics listed above. To ensure a diversity of perspectives, data collection sites were selected across ecological regions (lowlands, midlands, highlands, and the Senqu River Valley), geographical areas (rural, peri-urban, and urban) and facility type (hospital, health center, or non-profit organization). For data collected at health facilities, both government and Christian Health Association of Lesotho (CHAL) sites were invited to participate. These sites were selected with assistance from local experts with extensive experience in data collection in Lesotho.

2.2 Inclusion criteria and recruitment

Recruitment at the identified data collection sites began with contacting the appropriate local authority (local chiefs, medical superintendents, and head nurses). Inclusion criteria for the focus groups were that the participant be over 18 years of age and able to provide written consent to participate. Within communities, participants were recruited from local community meetings or with the assistance of the local leaders. Particular focus was placed on recruiting local leaders (e.g., chiefs, religious leaders, traditional health practitioners [THPs], teachers, and village health workers [VHWs]), as well as members of the general public. Medical superintendents or head nurses assisted in recruiting health care workers (HCWs) across departments and expertise at health facilities, including doctors, nurses, VHWs, data clerks, and other staff at health centers. Recruitment of mental health workers (MHWs) was facilitated by medical superintendents but also occurred through snowball sampling in communities. These focus groups included doctors, psychologists, counselors, social workers, employees of local organizations, and mental health advocates. Between five and ten

participants were recruited to each focus group. Additionally, a small number of key informants were unable to attend a focus group and so were interviewed individually.

2.3 Data collection

Data collection took place between April and July of 2023. Focus group and interviews mostly lasted between 40 and 105 minutes, with one outlier interview lasting 180 minutes. The data collection was conducted in English or Sesotho, depending on the preference of the participants. Participants were first read the information sheet about the study and allowed to ask any questions before agreeing to participant. Participants were then asked to sign or mark a consent form, before completing a brief demographic survey. Qualitative data collection used a semi-structured interview guide that was developed to capture perspectives on specific topics through the use of broad and specific probing questions. All groups were asked to define mental wellbeing and mental illness, to describe coping strategies and resilience resources used by different age groups, to explain gaps in mental health care provision, and to provide recommendations for improving mental health and mental health care. HCWs and MHWs were also asked to describe challenges in diagnosing and treating mental health conditions, interaction of service providers across systems and levels of care, and gaps in specific training for mental health experts. An overview of the study design, recruitment, and data collection can be found in Figure 1 below.

2.4 Data analysis

All data were audio-recorded with the permission of the participants. Sesotho recordings were translated and transcribed directly to English by the facilitator of the focus group/interview. All transcriptions were coded by the study lead (who was also one of the two focus group facilitators), using a codebook that was developed both deductively and inductively. All coding was done using Nvivo 1.7.1 statistical software. Themes were defined based on the coding, which were reviewed through member checking and peer review to establish trustworthiness[13].

2.5 Ethical considerations

This study was approved by the Lesotho Ministry of Health Research and Ethics Committee (ID01-2023)

[13] Creswell JW. Educational research: Planning, conducting, and evaluating quantitative and qualitative research. pearson; 2012.

Figure 1: Overview of study methods

SECTION 3: PARTICIPANT CHARACTERISTICS

Two hundred eighteen participants were recruited across 25 focus groups and four interviews (Figure 2).

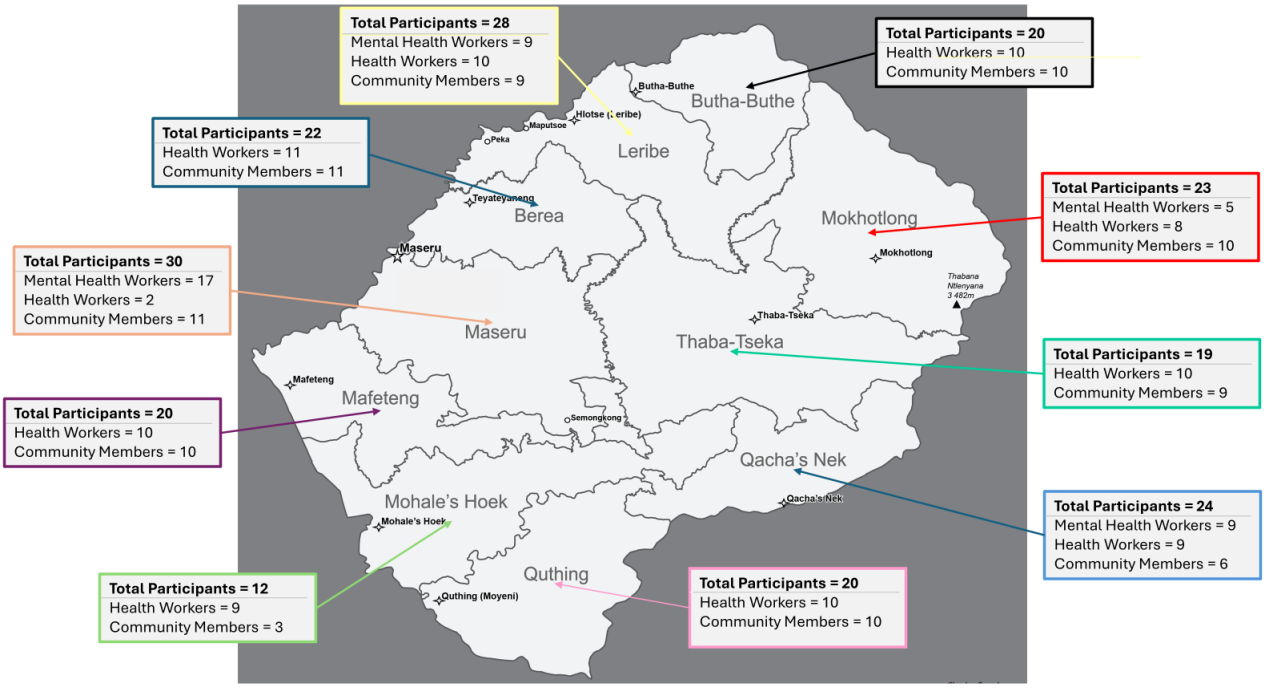


Figure 2: Focus group characteristics

Ten community focus groups were held across the ten districts in Lesotho; nine focus groups were held with health care workers (HCWs) across nine districts; and six focus groups were held with mental health workers (MHWs) across four districts. Three of the six MHW focus groups took place in Maseru, because of the disproportionate number of mental health professionals residing there.

Of the 89 HCWs who participated in a focus group or interview, 14 were male and 79 were female (Figure 3). Of the 40 MHW who participated in a focus group or interview, 8 were male and 32 were female. The community focus groups were more balanced by gender; of the 89 participants, 41 were male and 48 were female. On average, HCWs were slightly older than community members; their average ages were 43.51 (SD = 13.03) and 41.83 (SD = 16.19) respectively. MHWs were younger overall than the other groups, with an average age of 36.70 (SD = 9.42).

Most HCWs were nurses (n = 43), followed by village health workers (n = 24), doctors (n = 7) and THPs (n = 2). Thirteen participants represented other staff at health centers, including data clerks, counsellors, quality improvement officers, pharmacists, administrators, cleaners, and a nutritionist. Most MHWs were counsellors (n = 11), representatives of non-profit organizations or advocacy groups (n = 8), social workers (n = 6), psychiatric nurses (n = 6), or psychologists (n = 3). Within the community focus groups, nearly half of the participants were unemployed (n = 49), with smaller numbers of participants employed in agriculture (n = 6),

education (n = 4), as chiefs (n = 4), as religious leaders (n = 3) or as traditional health practitioners (n = 2). Twenty-one community focus group participants worked in other fields, such as food service and security.

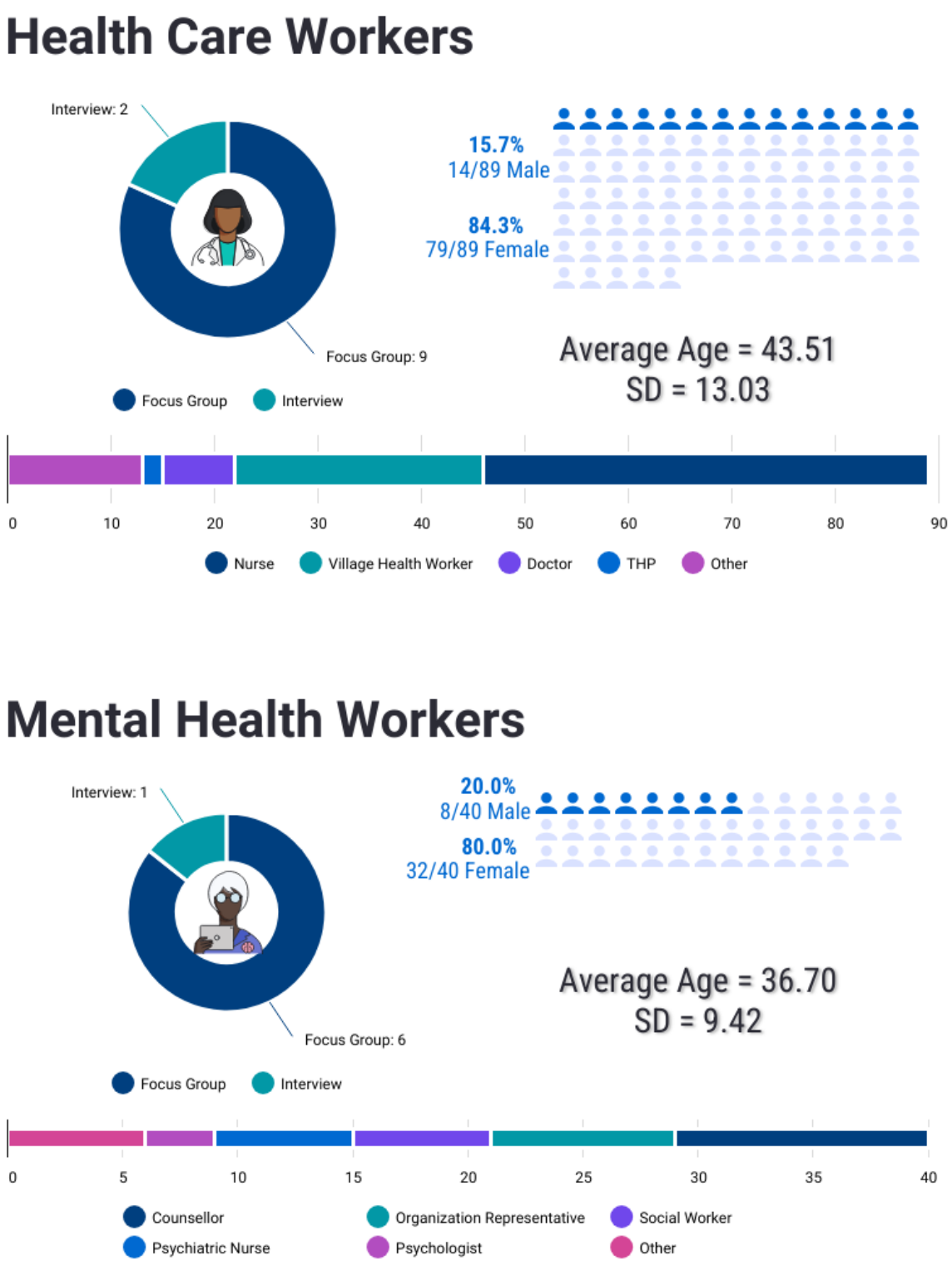


Figure 3: Participant characteristics

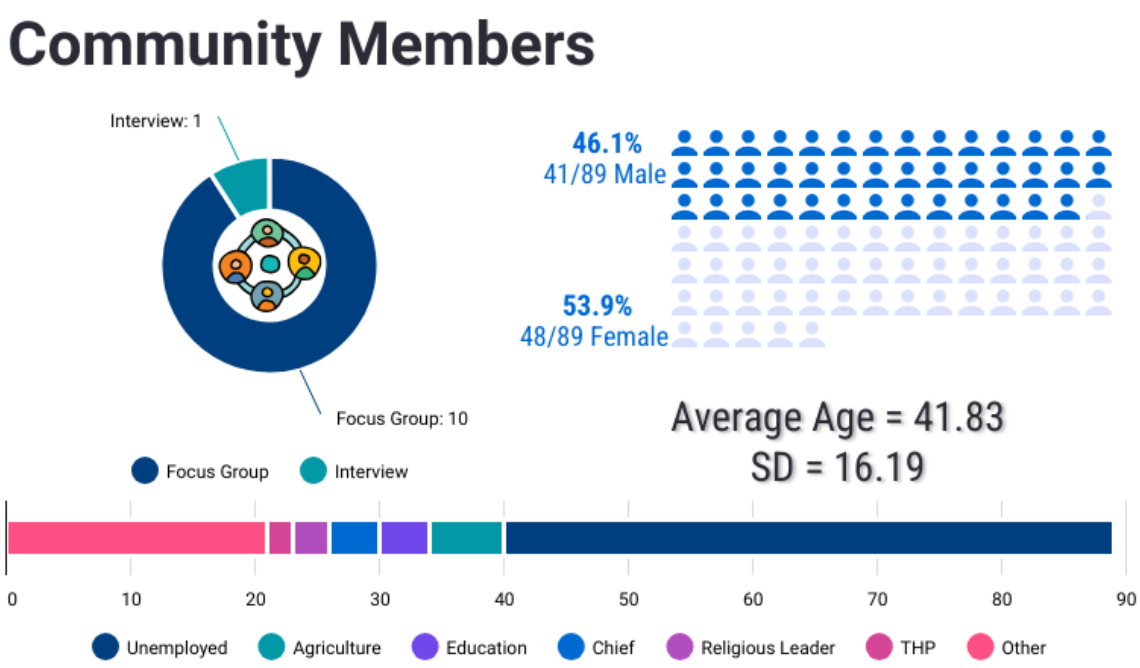
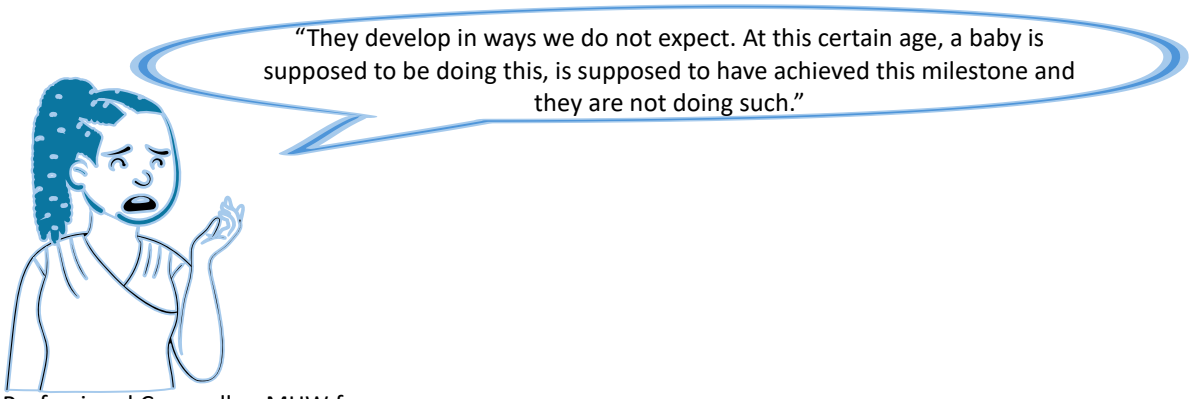


Figure 3: Participant characteristics (continued)

SECTION 4: MENTAL HEALTH IN YOUNG CHILDREN

4.1 Signs and symptoms of mental distress in early childhood

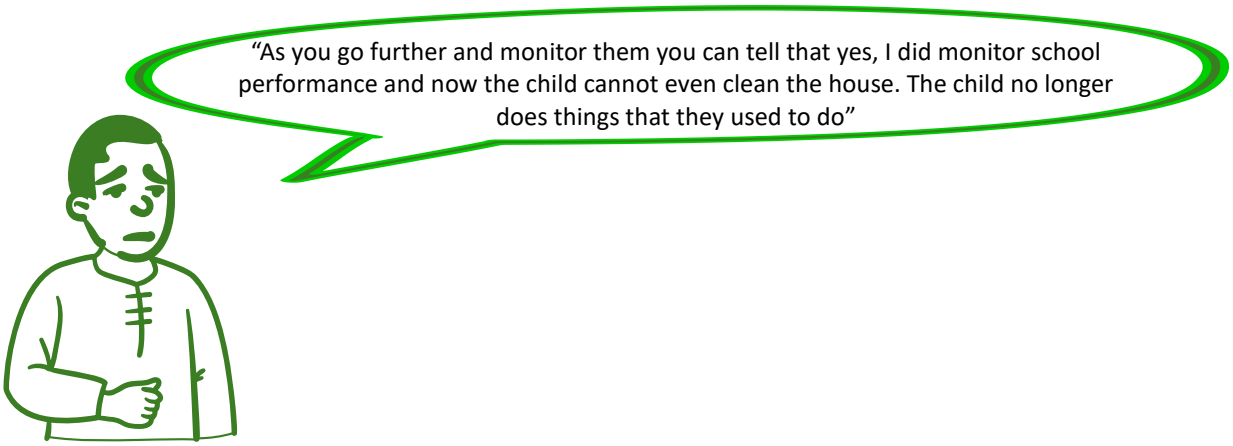
Participants in all focus groups were asked to identify signs and symptoms that very young (0 – 5-year-old) and young (5 – 10-year-old) children were mentally distressed. Within very young children, some health and mental health professionals identified missing developmental milestones as a possible indicator of mental health challenges:



Professional Counsellor, MHW focus group

Other participants described issues of attachment to a caregiver, like not wanting to be carried or crying when held. Finally, epilepsy was commonly misidentified as a symptom of mental health conditions in very young children.

Among young (5 – 10-year-old) children, somatic complaints were identified by some participants. Additionally, as children in this age group were maturing into school and increased responsibilities at home, many participants were able to identify changes in school performance or chores as possible signs that a child was struggling:



Village Health Worker, Community Focus Group

Other participants noted behavior changes included absent-mindedness and aggression, including poor treatment of animals and bullying.

Most participants identified signs and symptoms that a young child may be struggling with their mental health that applied to both age groups. General comments about behavior changes were most common. Within behavior change, aggression, moodiness, anxiety, self-isolation, disobedience, and fear around people were named. Regression, most commonly discussed as encopresis or enuresis, was also identified. Finally, suicidal ideation was mentioned rarely but notably, including in children as young as preschool. A summary of participant-identified signs and symptoms can be found in Figure 4.

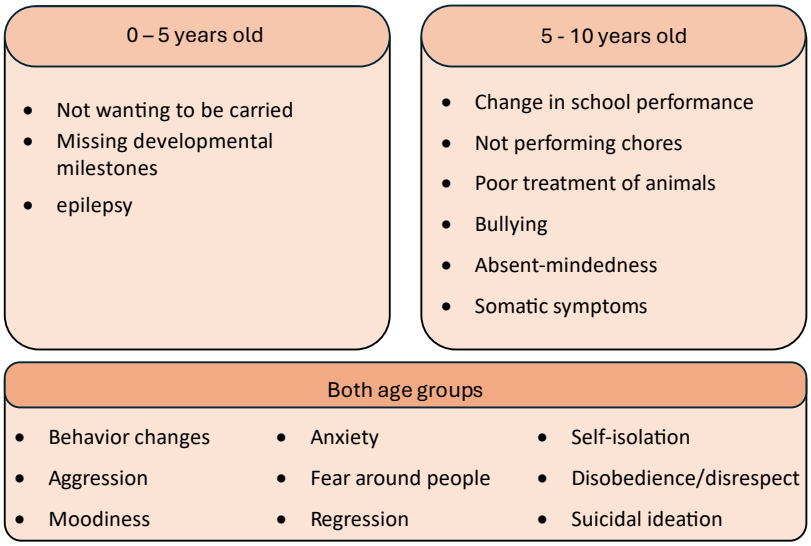


Figure 4: Signs and symptoms of mental distress in early childhood

4.2 Adversity and resilience in early childhood

Participants identified adversities and resilience resources faced by young children across individual, family, community, and national levels:

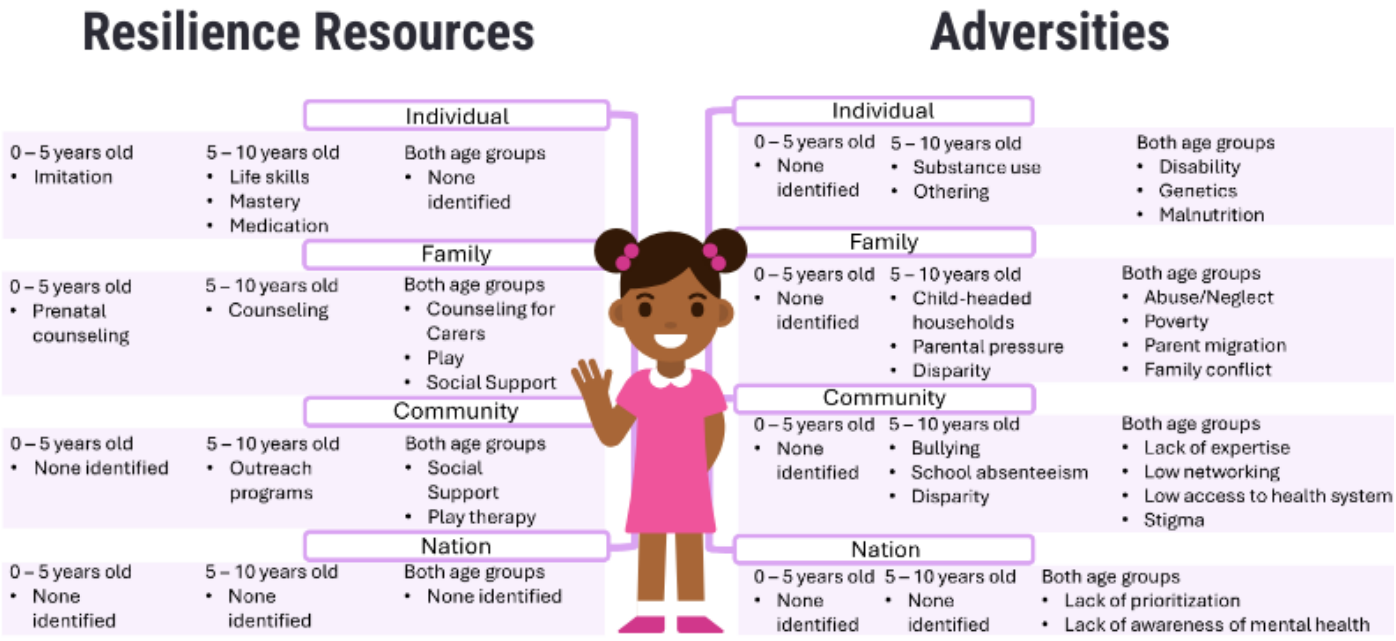
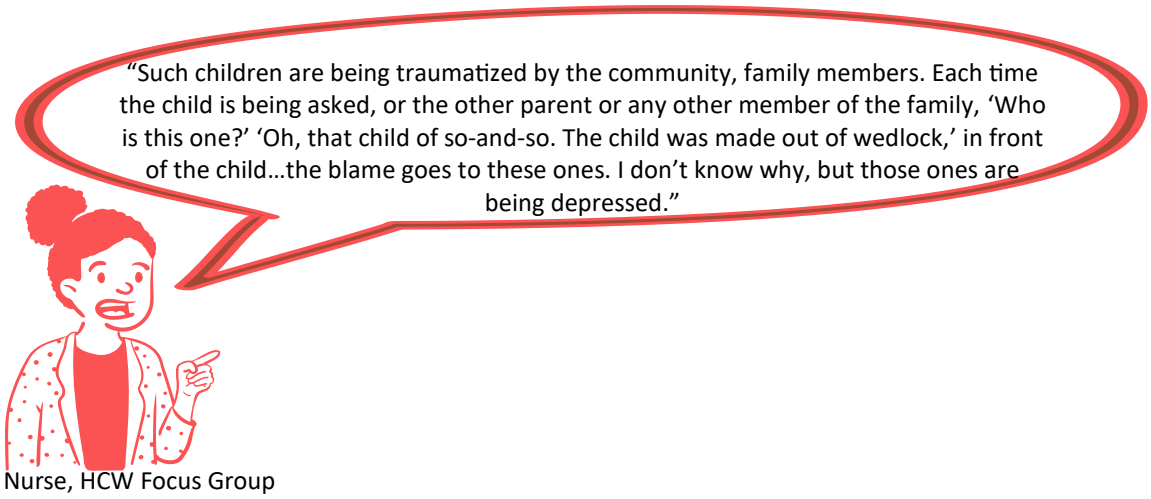


Figure 5: Adversity and resilience resources in early childhood

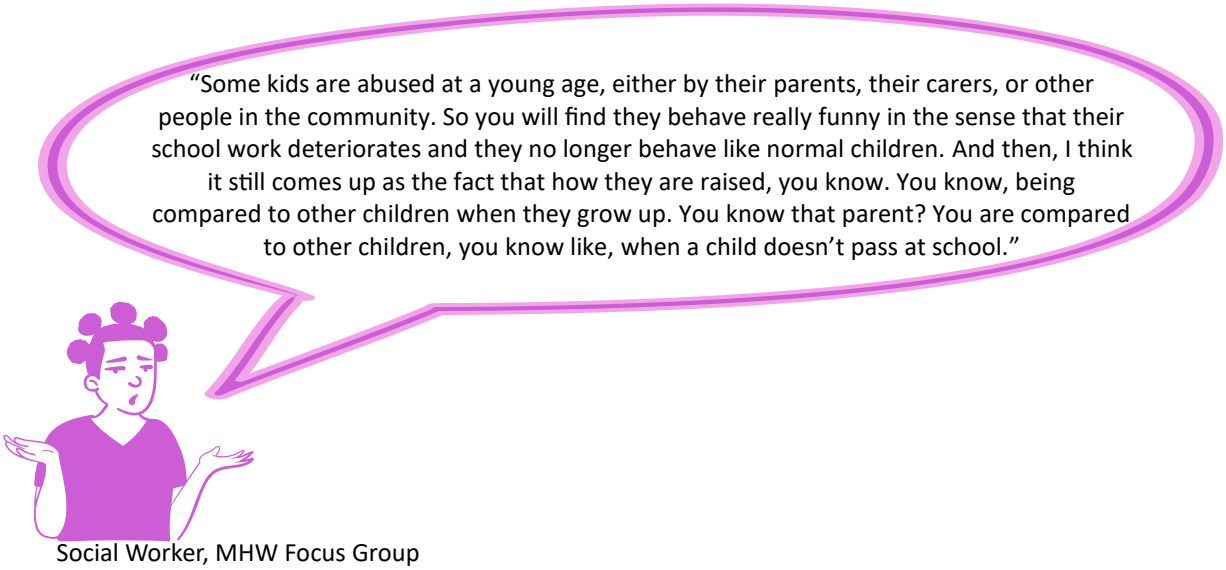
4.2.1 Adversity in early childhood

Interestingly, participants struggled to identify specific adversities related to very early childhood. At an individual level, genetics, having a disability, and malnutrition were identified as adversities that affected children under ten years of age, while substance use was noted specifically in children ages 5 – 10. Othering, or treating some children differently because of disability or family situation, was also noted:



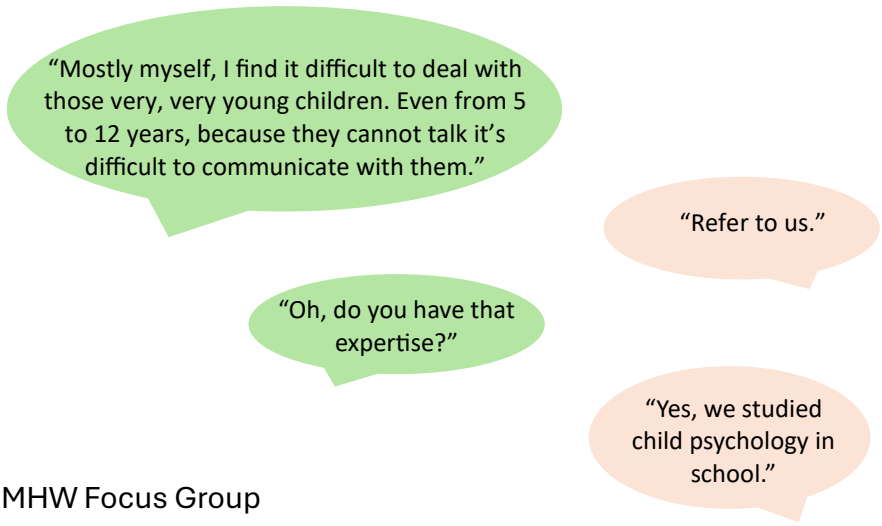
Nurse, HCW Focus Group

Within families, neglect and poverty were commonly discussed. Within the 5 – 10-year-old age group, poverty was more specifically connected to disparities as well; children were comparing their lifestyle, clothing, and food to that of their peers, and having less perceived affluence resulted in stress. Additionally, parental pressure to excel academically begins in this older age group, as children start school. Parental migration was also identified and related to poverty by some participants: a lack of local employment opportunities necessitated the travel of one or both parents to Maseru or South Africa for work. Participants reported that in some cases parents would not send money back, perpetuating financial strain on the children. Additionally, parents sometimes do not return to Lesotho, leading to feeling of abandonment within the children and adding financial and emotional strain on children's caregivers. For 5 – 10-year-olds, this abandonment could also result in child-headed households that leave children vulnerable to maltreatment, school absenteeism, and risky behaviors like the substance use mentioned above. Orphanhood was also identified as an adversity with similar risks. Family conflict was noted as impacting early childhood wellbeing, and this conflict included spousal conflict, gender-based violence, separation, divorce, and intergenerational conflict between children or parents, or grandchildren and parents. This conflict could include physical and sexual abuse, for both young and very young children:



Social Worker, MHW Focus Group

Within community settings, participants were aware that young children may struggle due to a lack of locally available child development and mental health experts such as child psychologists, psychiatrists, and counselors. Even when services were available at local health facilities or community-based organizations, these services could be difficult to access due to low-quality infrastructure like roads, and the cost of transportation. Networking was also a challenge; even participants working at the same facilities or within the same community were at times unaware of each other, or of the skills each could contribute to improving mental health in young children:



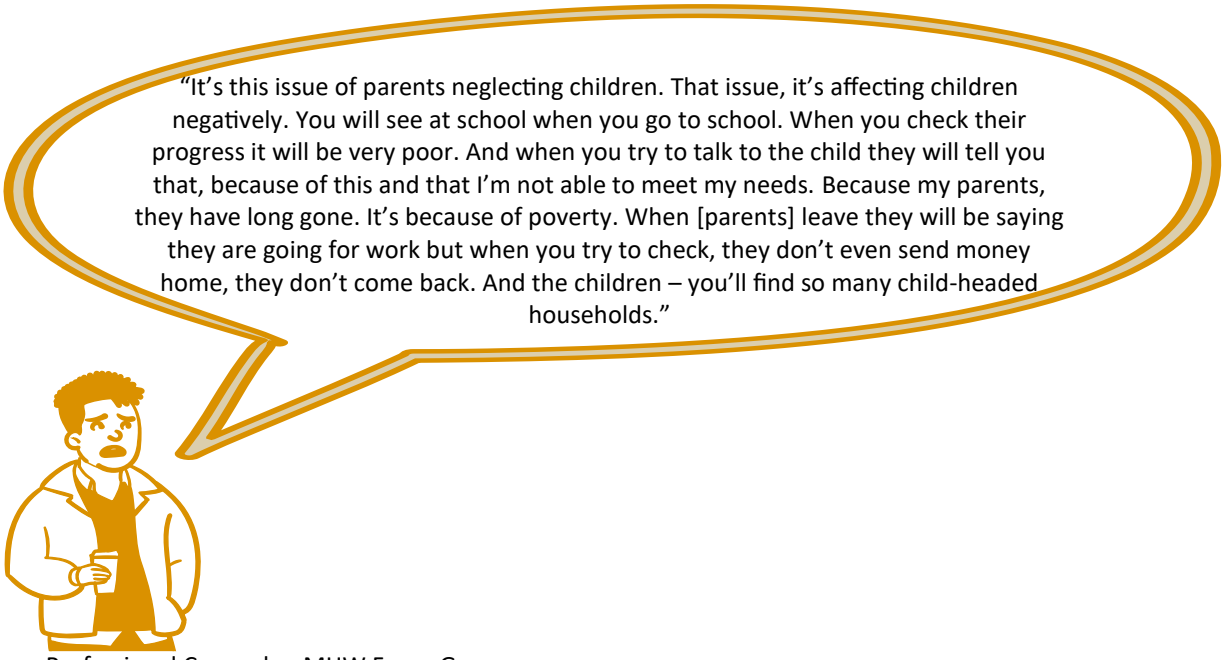
MHW Focus Group

Stigma was also recognized as present in communities and was directed at children from a young age. Participants noted that children with intellectual or physical disabilities and their families were ostracized, similar to the differential treatment of children born out of wedlock mentioned above. Stigma was also connected to a lack of knowledge of child development or

mental health that led adults to assume changes in child behavior were the result of attention-seeking or being naughty, without exploring potential underlying causes. Finally, within the 5 – 10-year-old age group, disparity continued to be a challenge, in addition to school absenteeism and being the victim or perpetrator of bullying.

At the national level, participants felt that there was a general lack of awareness and prioritization of mental health in early childhood. According to participants, this situation was reflected in the lack of child mental health professionals employed at national and community levels, and in the lack of funding for initiatives to promote early childhood wellbeing and detect and treat children in need of care.

Though presented separately, these adversities at multiple levels intersect and influence one another, as exemplified in the quote below:



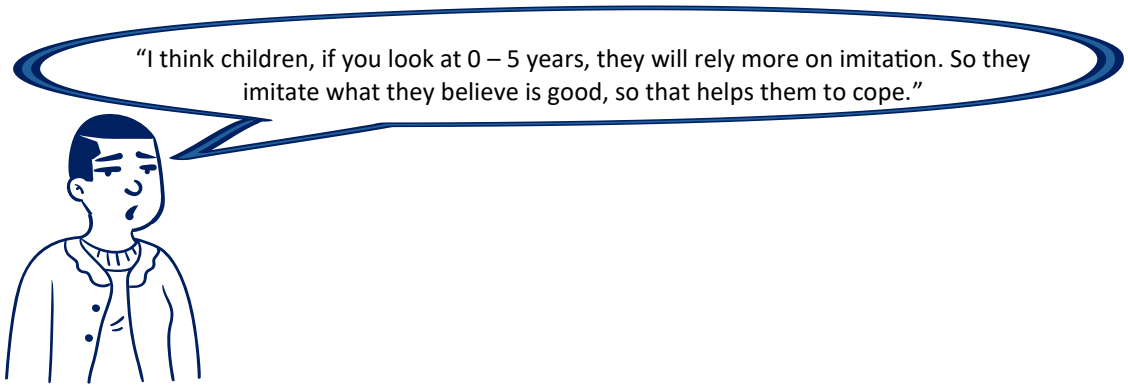
Professional Counselor, MHW Focus Group

In this example, the participant describes how poverty necessitates parental migration, which then leads to child abandonment and poor education outcomes. Additionally, the child identifies that they are unable to meet their needs, suggesting a lack of public assistance at community and national levels to support children in difficult circumstances.

4.2.2 Resilience resources to promote wellbeing and address mental health challenges in early childhood

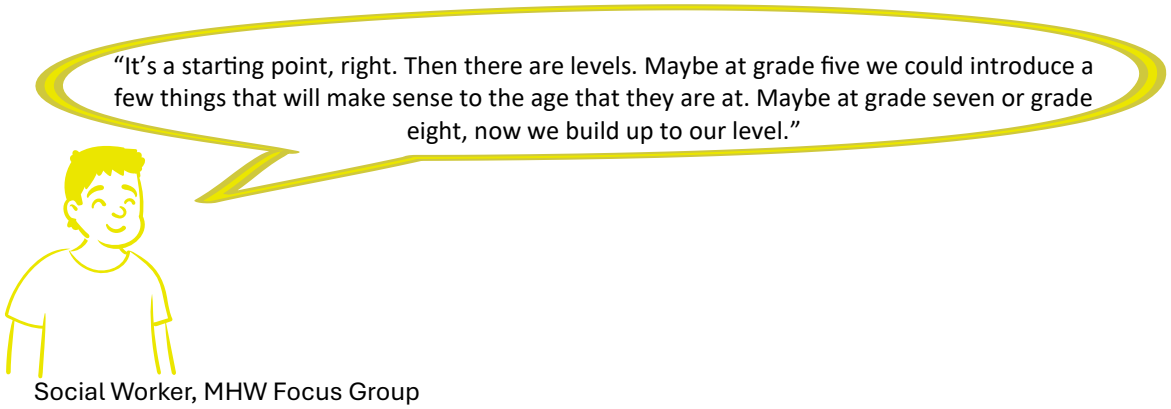
Though young and very young children face many difficulties in Lesotho, resources are available which can be leveraged to help them navigate these adversities, support healthy development, and subjectively thrive.

Within very early childhood, one participant identified that prenatal counseling was available at the district hospital, to ensure the health of the expecting parent and promote healthy fetal development. Another participant noted that young children sometimes learn and cope through imitation of the people around them:



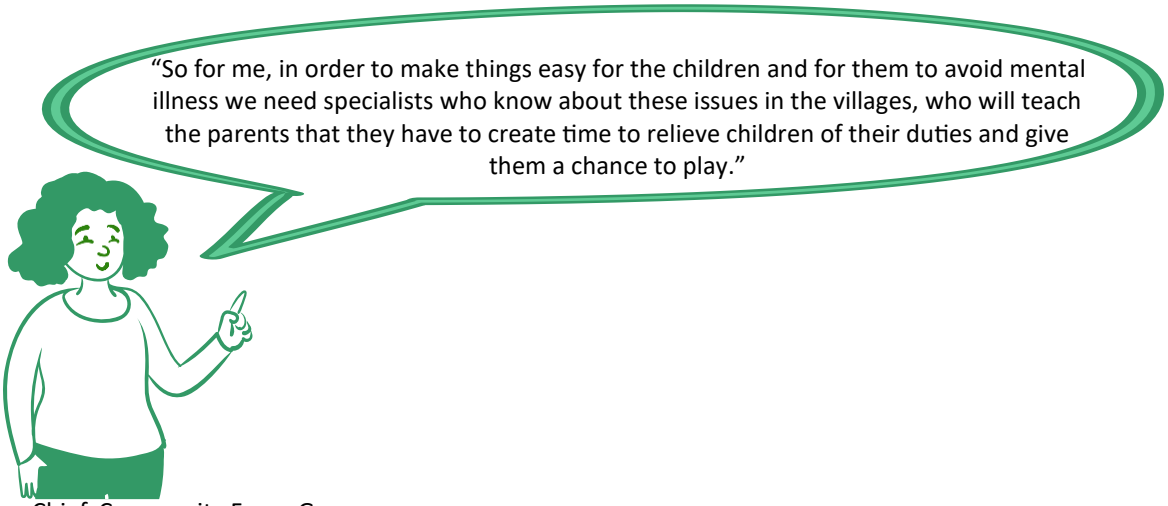
Professional Counselor, HCW Focus Group

For older young children (aged 5 – 10), participants noted that medication and counseling were available for children in some parts of Lesotho. Additionally, child-focused mental health outreach programming was to school-aged children through NGO's, CBO's, and health specialists like psychiatric nurses and psychologists. These programs, though, are not equally dispersed throughout the country and so access is limited. Participants also noted that maturation and attending school could build confidence and agency in children, fostering a sense of mastery that is associated with resilience. Finally, some participants mentioned that the required education curriculum in primary school includes life skills, though they also felt that the curriculum had not yet been fully implemented. Participants felt that this life skills training should be refined to further integrate mental health into the formal education system:



Social Worker, MHW Focus Group

Within all ages under 10, social support and the ability to play were recognized as fostering positive mental health. In fact, some participants suggested that more play areas should be developed in communities, to provide safe spaces for children to go and play together. Paired with this suggestion were comments from a few community members, that children should be allowed more time to play:



Chief, Community Focus Group

The participant quoted above voices the suggestion that more specialists be employed to teach parents. Many participants provided similar and more expansive opinions, suggesting that education be provided not only for parents but for entire communities. Beyond positive mental health promotion and the prevention of mental disorders through education, play therapy was recommended for children suffering mental health challenges, and counseling was recommended for parents. In this way, participants were collectively acknowledging the need for a multimodal framework that provides preventative and intervention programming for child mental health and targets both children and the influential adults and systems in their lives.

4.3 Moving forward: improving care for early childhood mental health

Participants were able to identify many adversities faced by young children in Lesotho, but also many resources to promote their wellbeing. All of these resources already exist in some areas of Lesotho but should be more equitably dispersed to support the entire country. Additionally, some of these resources could be further leveraged to better empower communities, caregivers, and young children in promoting wellbeing. One such resource is prenatal counseling. This prenatal counseling could include a client-centered educational program for expecting families about early childhood development, framed through the WHO Nurturing Care Framework[14] while also incorporating lived experiences such as nutrition and health care access for the mother, family composition and economic situation, community infrastructure and social connectedness, and national policies (Figure 6).

[14] Nurturing Care – A Framework for Early Childhood Development [Internet]. Available from: https://nurturing-care.org/

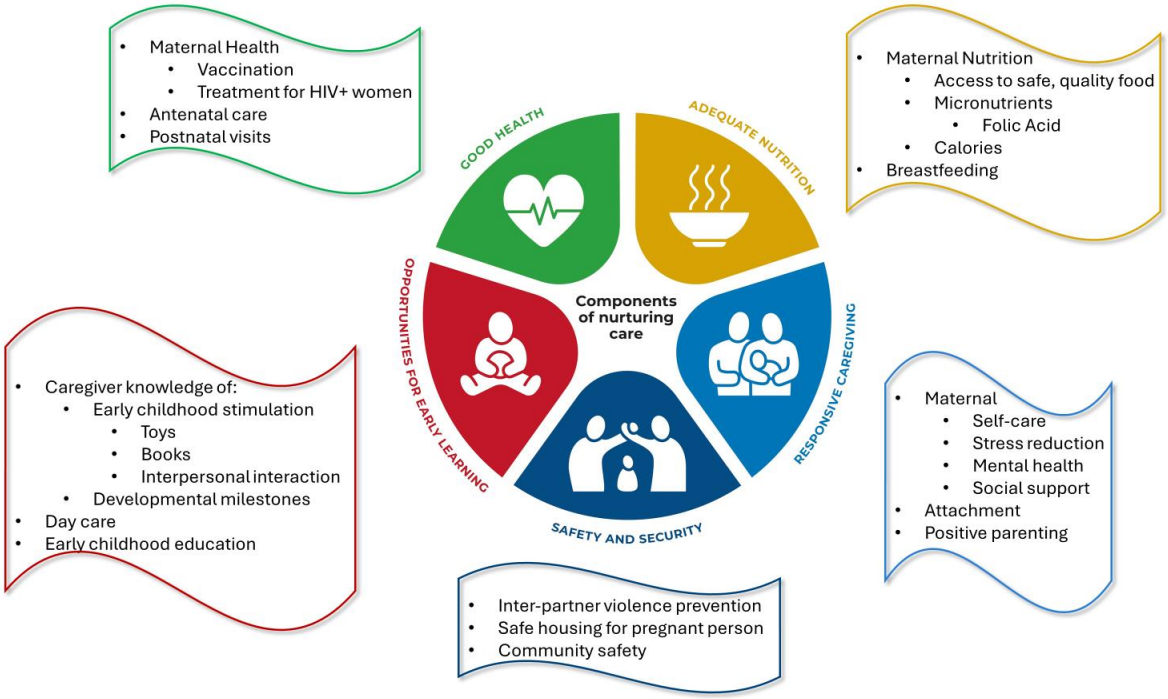


Figure 6: Components of early childhood development within a Nurturing Care Framework

Following a family systems[15] approach to care counseling and early childhood care provides the benefits of direct intervention to the child, and indirect intervention through improving the mental health of family members most closely interacting with the child. Additionally, one participant noted that children learn and cope through imitation, suggesting that combining an understanding of child development and child-caregiver relationships with fostering healthy self-care skills in caregivers could equip caregivers to model positive mental health strategies for their children, beginning from a young age.

Caregivers should also be equipped to model healthy communication strategies that are sensitive to a child's age developmental stage, particularly as interpersonal conflict, abuse, and neglect were commonly identified adversities facing children[16,17]. Healthy communication is essential to the constructive discipline and responsive caregiving that are part of positive parenting[18], and in turn provides children with a secure attachment and sense of safety that facilitates confident exploration of the world and consequent maturation. Healthy communication can also be mimicked by children, and a caregiver modeling a healthy

[15] Johnson BE, Ray WA. Family systems theory. Encyclopedia of family studies. 2016 Feb 23:1-5.
[16] Black MM, Walker SP, Fernald LC, Andersen CT, DiGirolamo AM, Lu C, McCoy DC, Fink G, Shawar YR, Shiffman J, Devercelli AE. Early childhood development coming of age: science through the life course. The Lancet. 2017 Jan 7;389(10064):77-90.
[17] Black MM, Behrman JR, Daelmans B, Prado EL, Richter L, Tomlinson M, Trude AC, Wertlieb D, Wuermli AJ, Yoshikawa H. The principles of Nurturing Care promote human capital and mitigate adversities from preconception through adolescence. BMJ Global Health. 2021 Apr 1;6(4):e004436.
[18] Parenting for Lifelong Health [Internet]. www.who.int. Available from: https://www.who.int/teams/social-determinants-of-health/parenting-for-lifelong-health

communication style can foster the socioemotional development that is critical to positive mental health in young children.

Safe communities and homes are another essential piece of early childhood development[19]. Safe spaces promote healthy development, and children possessing a sense of safety have confidence in exploring the world. Safety includes homes free of violence - physical, sexual, and emotional - and harsh discipline. Safe homes are also spaces that allow for developmentally appropriate play and exploration, by minimizing risk through actions such as safe storage of sharp objects, poisons, and medication. Safe communities should also be promoted – through violence reduction and maintenance of clean, pollution-free spaces for children and families.

Early childhood stimulation, at home and in communities, also fosters wellbeing[20,21]. This stimulation includes activities like playing, reading, and interpersonal interaction. Many participants suggested the need for community playgrounds, to provide children a space to play. Aside from being a fun way to release energy, play fosters physical, cognitive, emotional, and social development, therefore promoting positive growth. Through play, children learn problem-solving, emotion regulation, and teamwork; explore the world; and gain confidence. Each of these skills is related to coping strategies that foster resilience and promote positive mental health and wellbeing. Play can happen both individually and with other people, and can include imagination but also the use of toys as simple as pots, pans, and basins. In addition to play, books – picture books and textual books – also fosters cognitive development and imagination. Though not mentioned by participants, community libraries and initiatives to provide books in the home should be explored. In young children, playing and reading also often includes interpersonal interaction, caregivers and siblings can play or read to the child. In this way, play and reading can also help relationships to develop.

Access to books and reading could also take place through early childhood education at day cares and schools. Though access to early education was not recognized as a mental health resource within this study, early childhood education is widely seen to have many benefits in promoting wellbeing and development from a young age. Early childhood education centers can be spaces that provide nutrition through meal plans, spaces for parental learning and support, spaces for vaccination, spaces that provide socioemotional development through peer interaction, and spaces for cognitive development through exploration and play. Access to quality early childhood education should be prioritized and expanded, to provide Basotho children this foundation for growth and development. Additionally, stakeholders including

[19] Pierce H. Nurturing care for early childhood development: Path to improving child outcomes in Africa. Population Research and Policy Review. 2021 Apr;40:285-307.
[20] Enelamah NV, Lombe M, Betancourt TS, Williams DR, Shen C. Variations in risk, resilience, and protective factors for cognitive and socioemotional development among 3-to 4-year-old children in Nigeria: A multilevel modeling. Early Childhood Research Quarterly. 2023 Jul 1;64:162-73.
[21] Koshy B, Srinivasan M, Gopalakrishnan S, Mohan VR, Scharf R, John S, Beulah R, Muliyil J, Kang G. Early childhood stimulating environment predicts later childhood resilience in an Indian longitudinal birth cohort study. Children. 2022 Nov 9;9(11):1721.

caregivers, local leaders, and government should be sensitized to the importance of providing quality early childhood education, in developing a healthy nation.

Beyond early childhood education, primary school offers possibilities for wellbeing promotion through a life skills curriculum, which could be adapted to include more topics on mental health. Additionally, schools should be capacitated with mental health professionals who are able to identify children who may be struggling, intervene early, and connect them and their families with resources such as economic and mental health support and violence prevention.

Finally, child mental health does not depend on the child alone, but also on the primary adults in the child's life[22,23]. A focus on child mental wellbeing should therefore also include support for caregivers, which could include home visits from village health workers and social workers, local peer support groups for parents and expecting parents, initiatives to promote physical and mental health in caregivers, and economic empowerment.

Though presented as individual components of child mental wellbeing, the above factors interact as a network, resulting in developmental cascades that can influence holistic functioning wellbeing across developmental domains. As such, initiatives to foster mental wellbeing in early childhood should be multimodal, targeting not just health or nutrition or caregiving, but addressing multiple domains that impact a child's lived experiences (Figure 7).

Summary

- Young children in Lesotho face challenges in their families and communities that may affect their mental wellbeing
- Though resources are available to support children and their families, these resources are not equitably distributed across the country
- The mental health of young children has not been prioritized in Lesotho, and more awareness needs to be raised about early childhood mental health within families, communities, and at the national level
- Multimodal interventions are needed to support early childhood mental wellbeing

[22] Alexander PC. Intergenerational cycles of trauma and violence: An attachment and family systems perspective. WW Norton & Company; 2014 Dec 15.
[23] Honda T, Tran T, Popplestone S, Draper CE, Yousafzai AK, Romero L, Fisher J. Parents' mental health and the social-emotional development of their children aged between 24 and 59 months in low-and middle-income countries: A systematic review and meta-analyses. SSM-Mental Health. 2023 Dec 1;3:100197.

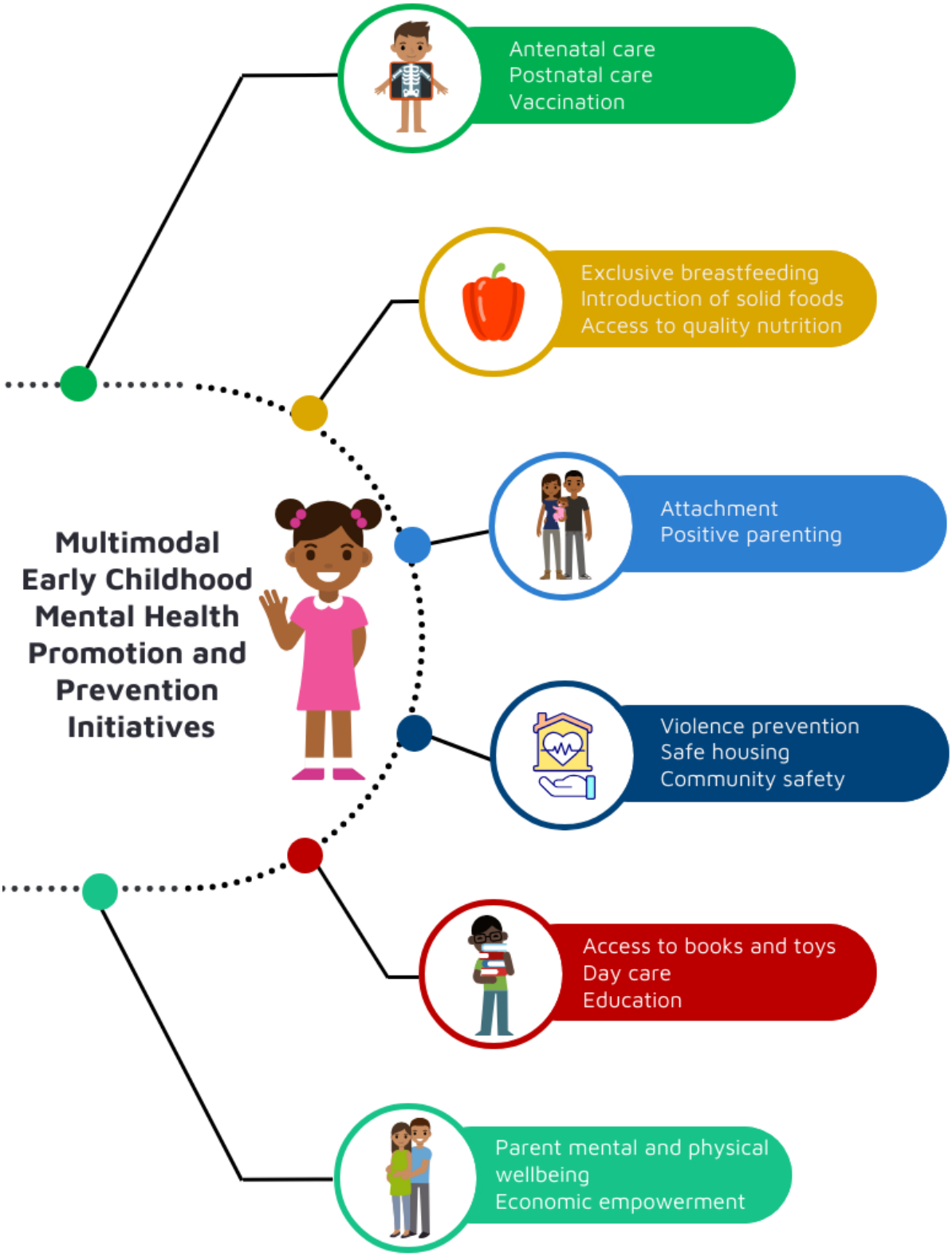


Figure 7: Multimodal early childhood mental health promotion and prevention initiatives

SECTION 5: MENTAL HEALTH IN ADOLESCENTS AND YOUNG ADULTS

5.1 Signs and symptoms of mental distress in adolescents and young adults

When asked to identify signs and symptoms that adolescents may be struggling with their mental health, participants identified behavioral, cognitive, emotional, social, and physical indicators (Figure 8).

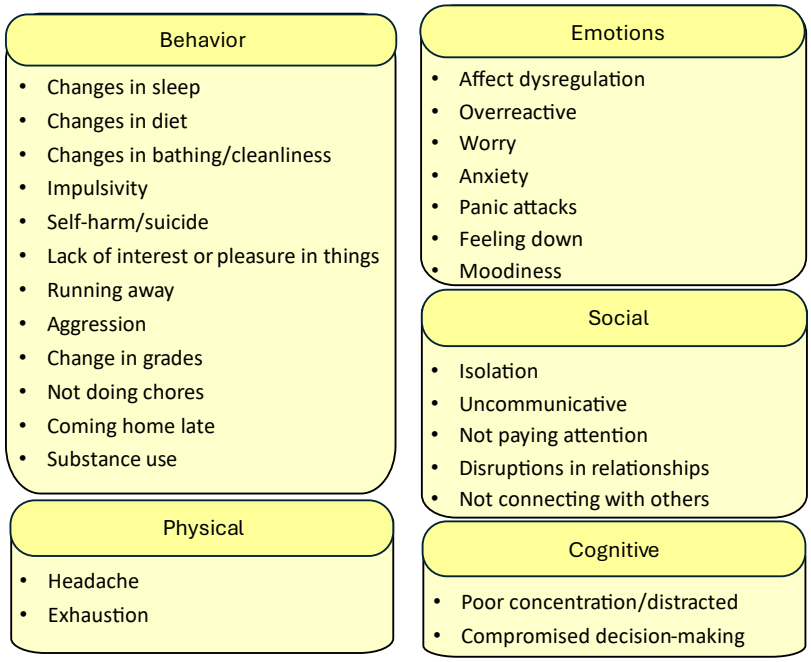
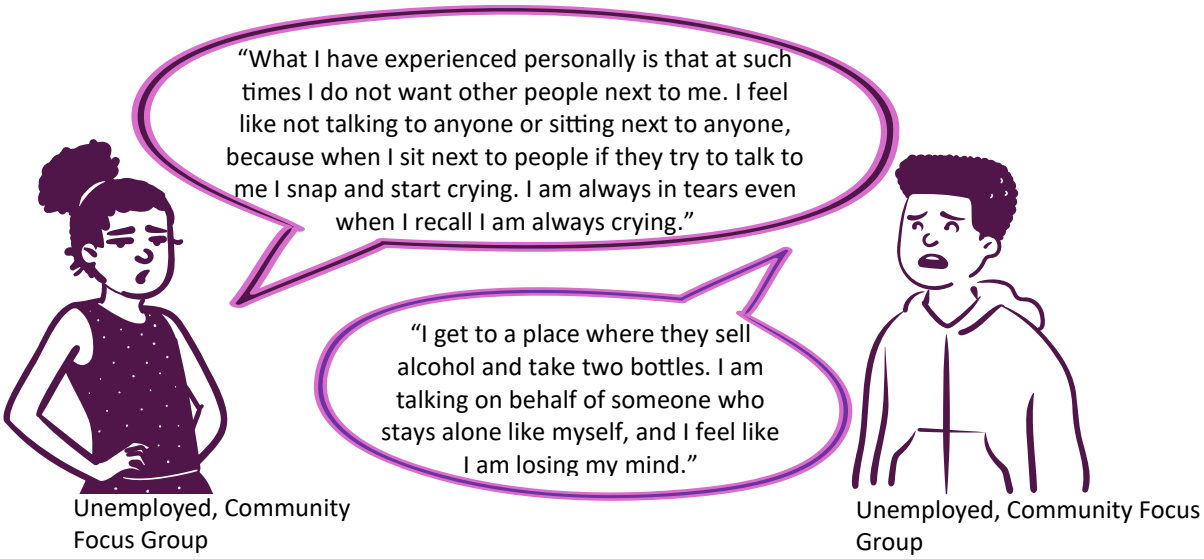


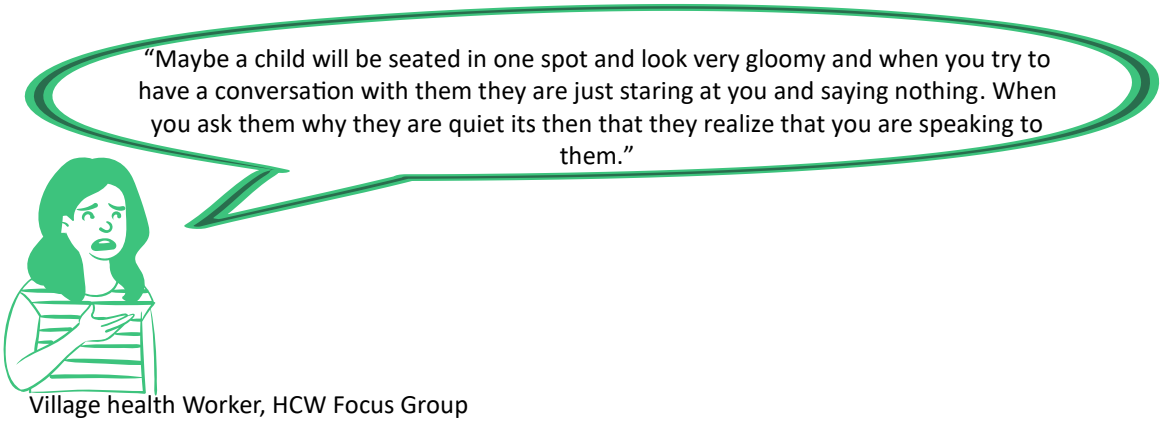
Figure 8: Signs and symptoms of mental distress in adolescence and young adulthood

Some participants described their current or earlier personal experiences with mental distress as youth, including how mental distress affected them:



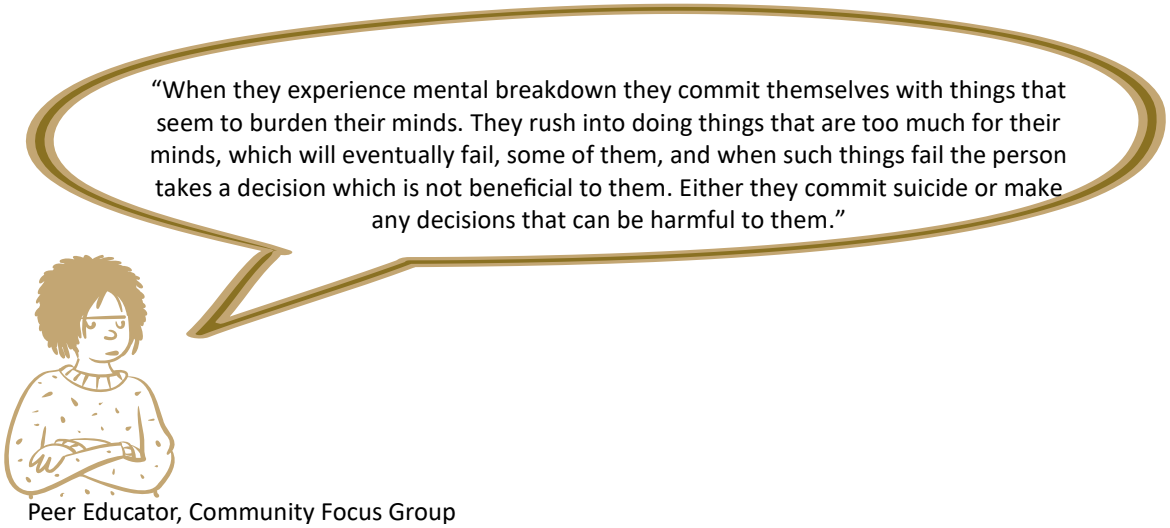
In this example, participants describe behavioral changes such as alcohol use, social changes such as self-isolation, and emotional responses including crying, as symptoms they have

experienced of mental distress. Isolation and distractedness were also mentioned by multiple health care workers:



Village health Worker, HCW Focus Group

Other participants observed impulsivity in adolescents, which could be a sign of mental distress or even lead to mental distress. One community member noted that impulsivity could cascade to poor decision-making:



Peer Educator, Community Focus Group

Both the village health workers and the peer educator quoted above note emotional, behavioral, and social changes, but also identify cognitive changes that can be associated with mental distress: being distracted and compromised decision-making. In these examples, as in the example of the unemployed adolescent, participants identified multiple interacting symptoms. As such, many participants seemed aware that mental distress can cascade to affect multiple life domains.

5.2 Adversity and resilience in adolescence and young adulthood

Participants identified adversities and resilience resources faced by adolescents and young adults across individual, interpersonal/family, community, and national/global levels (Figure 9).

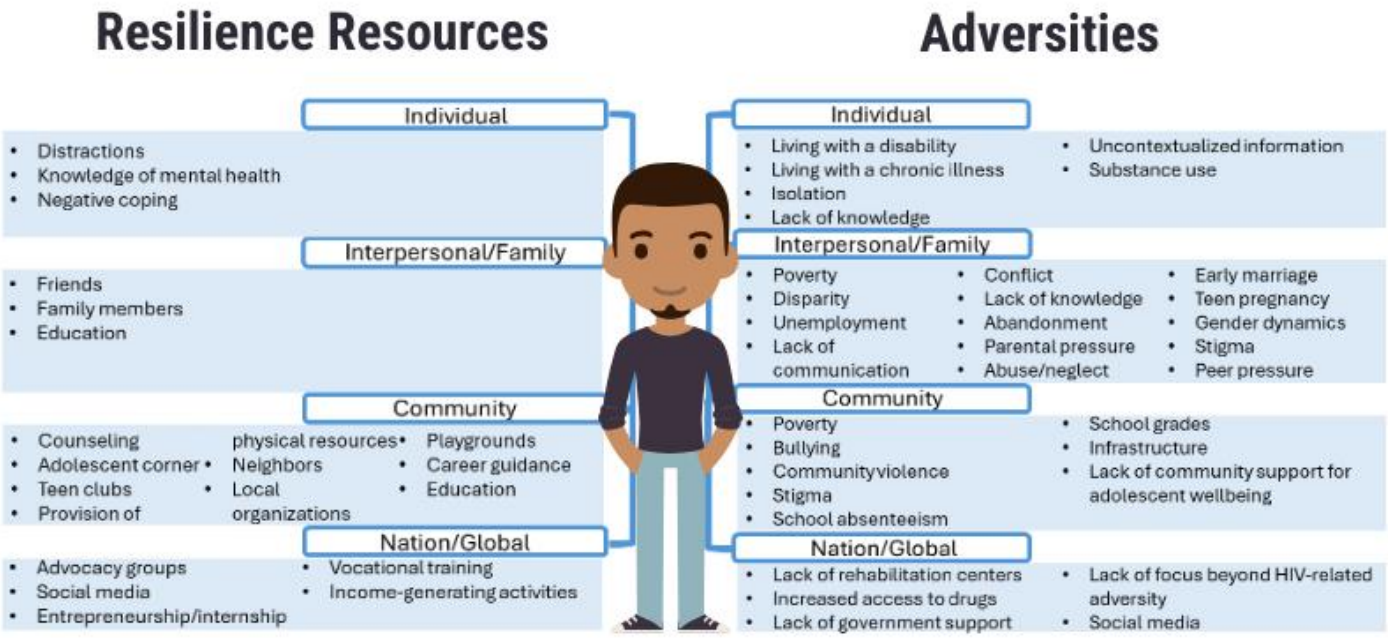
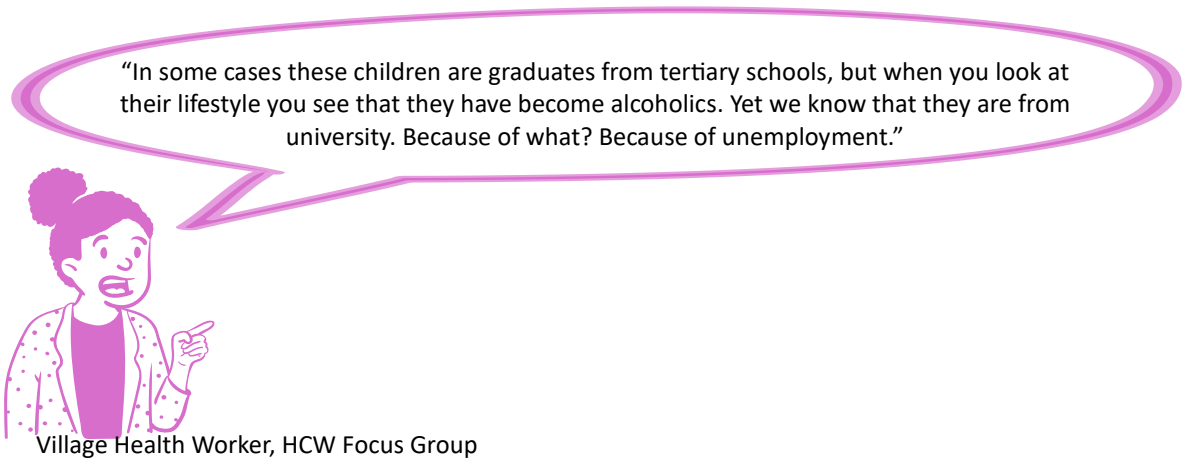


Figure 9: Adversity and resilience resources in adolescence and young adulthood

5.2.1 Adversity in adolescence and young adulthood

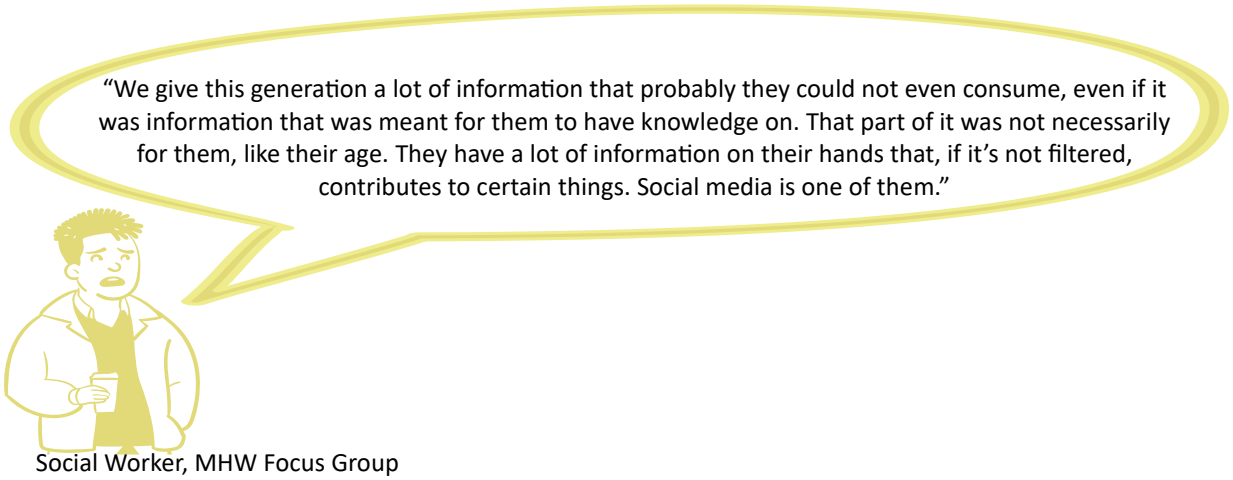
Individual adversity

Within adolescent and young adult individuals, living with a disability – physical, intellectual, or mental – or with a chronic illness was identified as an adversity. Isolation and living alone were also considered risk factors for developing mental health conditions. In older youth, unemployment was noted as a major stressor that is connected to other aspects of the youth's life in ways that can compound risk factors, including compromised relationships with loved ones and substance use:



Village Health Worker, HCW Focus Group

Interestingly, knowledge – both uncontextualized knowledge and a lack of knowledge – were identified by different participants as causing stress within this age group. Regarding a lack of knowledge, participants mentioned a lack of education on employment, puberty, adolescent development, and mental health at home and in school. For the participants noting stress related to uncontextualized knowledge, they felt that adolescents had access to more information than previous generations, and that this could be harmful if the information was age-inappropriate or if young people did not supportive adults who could help them interpret and make meaning of information. Unregulated access to the internet was identified by some participants as a source of harmful information:



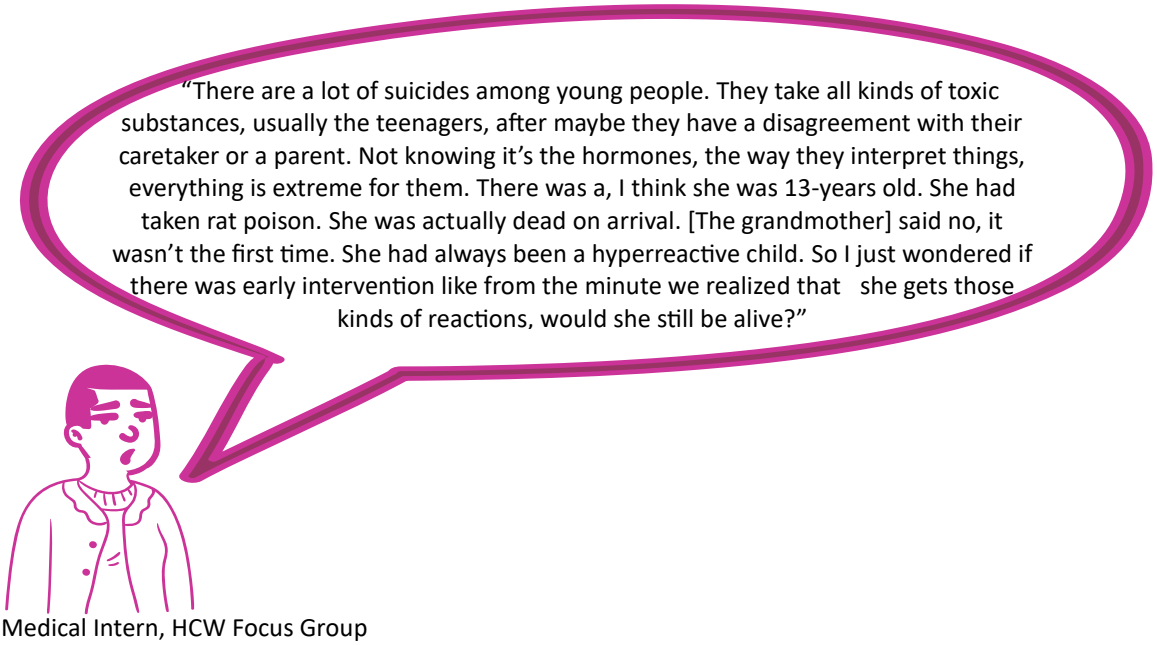
Social Worker, MHW Focus Group

Interpersonal/Family adversity

Interpersonal and family adversities were also identified within this age group. Interpersonally, adolescents may be navigating early love, as they begin to feel romantic and sexual interest in others. Peer pressure may lead to adolescents engaging in sexual intercourse at a young age. Participants also noted that relationships can in some cases lead to teenage pregnancy, the stress of parenting as a young mother, and early marriages. Early marriages were perceived as risky situations associated with power differentials between girls and their husbands and in-laws, gender-based violence, and early divorce. Sexual identity was also mentioned in multiple focus groups as an adversity; adolescents and young adults identifying as LBGTQ+ were likely to be misunderstood and discriminated against.

Unemployment and poverty were seen to affect families, just as they do individuals. Poverty can lead to school absenteeism or prevent youth from pursuing tertiary education. Poverty could also result in young girls in particular seeking blessers, which can put them at greater risk of gender-based violence and health, as well as mental health, concerns. Additionally, poverty can result in disparities, with youth in lower-income housing facing discrimination and bullying. Additionally, youth may compare their living standards to peers, and this may affect their self-esteem as they see peers able to afford the clothing and school supplies that they cannot. A discontent with family standards may also lead to sex work and other risky behaviors.

Within families, conflict, poor communication, and a lack of knowledge were identified as potentially intersecting adversities that can affect the mental wellbeing of youth. Conflict between partners could range from verbal disagreements to domestic abuse and inter-partner violence, which some participants felt was normalized within society. Conflict could also happen between caregivers and their adolescent or young adult children. Conflict between caregivers and youth can result when parents shift their stress to children in maladaptive ways, including physical, emotional, and sexual abuse and physical and emotional neglect. Conflict was sometimes described as parents pressuring children regarding grades and careers. Other participants noted that parents could sometimes over monitor their children, who are entering adolescence and young adulthood and therefore seeking greater autonomy. Some of the youth participants in the study noted that they did not feel like they were free to speak to their parents, and that their parents infantilized them. One young participant noted that youth who feel unable to speak freely at home may redirect their frustrations to other children, thereby becoming perpetrators of violence. This situation may be tied to a lack of knowledge of adolescent development in both youth and parents, paired with youth and parents not knowing how to effectively and respectfully communicate with one another as youth strive for more freedom. At its most extreme, conflict and communication challenges in families were described as driving youth to substance use and to running away from home and living on the streets. In one tragic case, a lack of awareness and communication seemed related to an adolescent committing suicide:



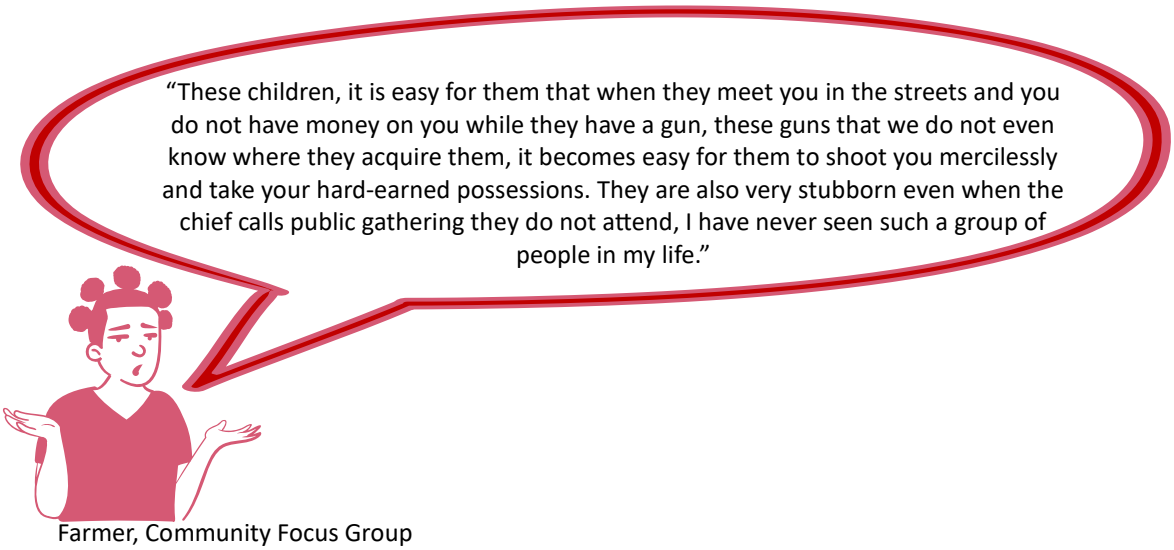
Medical Intern, HCW Focus Group

In other cases, participants noted that youth lack guidance from caregivers. Absentee parents were cited as one reason, but in other cases adolescents face abandonment or parental death. Orphanhood can also lead to discrimination or "othering" as orphaned children are treated differently than other children in the household. As with younger children, participants noted that caregivers would sometimes talk about the adolescent as though the adolescent was not there, without engaging the child in conversation or acknowledging that conversations about

their deceased parents may be painful for them. Discrimination and stigma can also result from disclosure of sexual orientation or gender identity in families, or from teenage pregnancy, all of which again can lead to "othering" of these youth. Finally, a lack of knowledge of mental health, and the impact of these adversities on the mental health of adolescents and young adults, can lead to stigma or minimizing of warning signs for mental health challenges. As with young children, adolescent and young adult behavior can be dismissed as attention-seeking, without further exploring whether the behavior may be a sign of more serious struggles.

Community adversity

Within communities, youth poverty was related to community violence through crimes and criminality, which were considered to be a source of money through theft and illegal mining. In Mafeteng in particular, gang membership was connected to youth perpetration of violence, but also victimization. Youth poverty could also result in school absenteeism, putting adolescents and young adults at greater risk for substance use, abuse, and gang membership. Youth in school could be subject to bullying related to their grades. Youth in school and out of school can be at risk of bullying and stigma because of their socioeconomic status, sexual orientation, gender identity, or mental health status. Adolescents and young adults are also faced with peer pressure that can lead to risky behaviors that can impact mental health, such as substance use, theft, and unsafe sex. A lack of systemic and community support for adolescents and young adults was considered to create multiple adversities impacting wellbeing. A lack of physical resources like transportation hinders mental health professionals from conducting school outreach programs which could inform school staff and youth about mental health. Community leaders and police may be hesitant to interfere in what are viewed as family issues, which in some communities has allowed abuse and neglect to continue in households. Challenges in accessing appropriate documentation prevent some adolescents, like orphans, from accessing financial and other supports to which they have a right. Some participants felt that the knowledge to address some of these adversities was available to community and government leaders, but that the will to implement change was lacking. Finally, in some communities, participants noted that the younger generation was not adhering to social norms like attending public gatherings when the chief has called for them. Participants did not identify factors contributing to this disengagement, but it was viewed as disrespectful and damaging to community connection and safety:

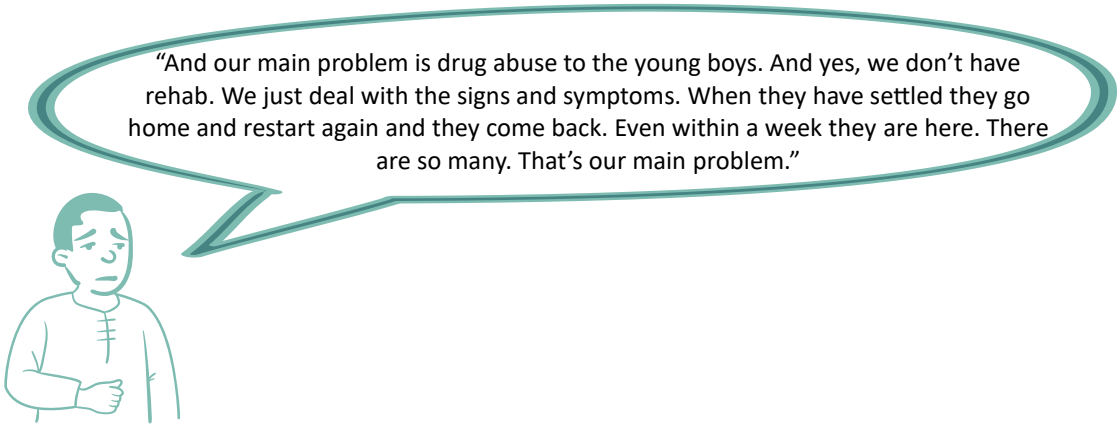


Farmer, Community Focus Group

National/Global adversity

Many of the systemic challenges identified as the local or district level also applied at the national level, including difficulty accessing documentation and limited transportation preventing mental health education for youth and caregivers. Additionally, many services offered by NGOs and the government were noted to only be available to people living with HIV, which excludes other youth who may be vulnerable and struggling. Participants felt that these services should be expanded and made available beyond people living with HIV. As with local adversities, participants perceived a lack of implementation of initiatives to promote youth wellbeing as a lack of will to act.

Substance use was also identified by many participants as a major challenge affecting youth, particularly boys and young men. In additional to alcohol and marijuana, the most common substances mentioned by participants, access to crystal meth and cocaine is increasing. Substance use may be an attempt to cope with mental health challenges that youth are facing but can also cause or exacerbate mental health conditions. One mental health worker pointed out that substance use can interact with psychiatric medication. Because Lesotho has no rehabilitation center, mental health workers struggle to offer appropriate services to youth facing addiction. Currently, youth are admitted to Mohlomi Hospital to treat substance use, though Mohlomi is not equipped to treat addiction. This situation places further strain on Mohlomi's limited resources, and can lead to relapses:



Nurse, MHW Focus Group

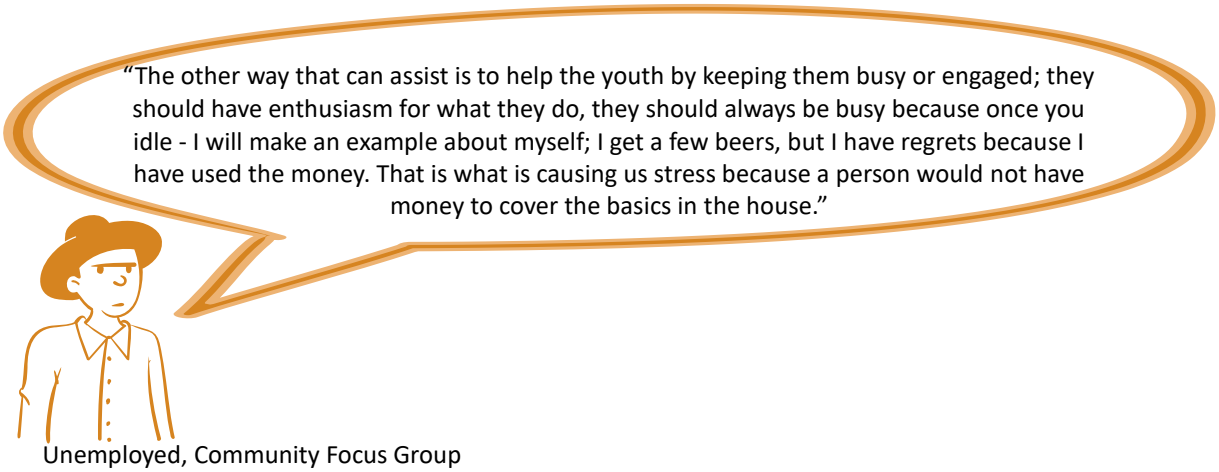
Globally, social media was perceived as an adversity within this age group, as it is a place where youth can compare themselves with other youth around the world. Perceived disparities can lead to mental distress. Additionally, adolescents and young adults are using social media to voice suicidal ideation, but these vulnerable youth often cannot be identified in time to prevent a suicide attempt. One participant noted that social media can lead to human trafficking, as vulnerable young people connect with predators online. More broadly, the internet can be a source of knowledge that can be harmful, such as access to illegal drugs.

5.2.2 Resilience resources to promote wellbeing and address mental health challenges in adolescence and young adulthood

As with adversities, focus group participants identified resilience resources across individual, interpersonal, community, and national/global levels. Also as with the identified adversities, these resources intersected with each other across levels, to support the wellbeing of adolescents and young adults.

Individual resilience

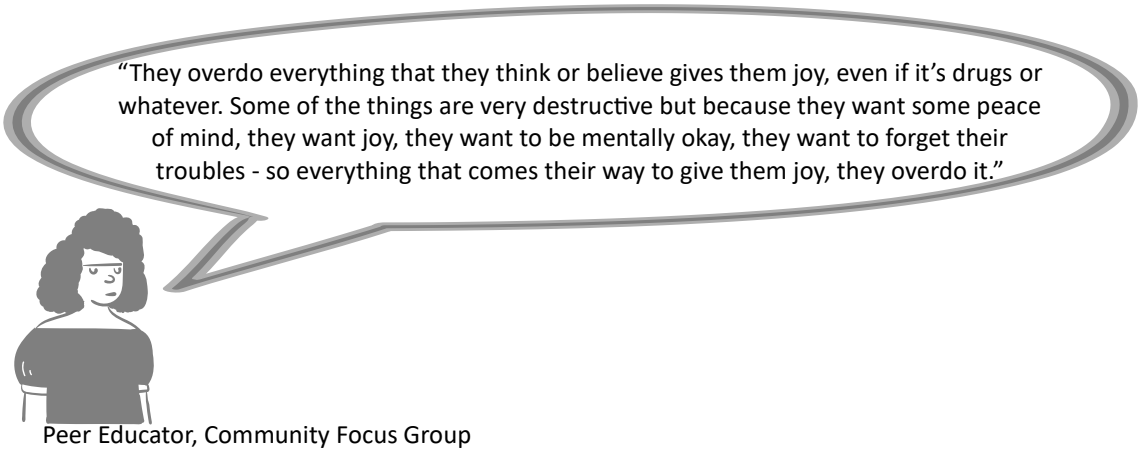
Youth in this age group use distractions, busyness, and engagement to take their minds off the difficulties they are experiencing. For some, listening to music or playing sports can be a way to cope. Additionally, engagement was viewed as way to prevent idleness that could encourage unhealthy behaviors or negative coping strategies:



Unemployed, Community Focus Group

Additionally, while a lack of knowledge was identified as an adversity, participants felt that young people were more knowledgeable about mental health and mental health issues than previous generations. Organizations were identified that used games as education tools to teach coping and resilience, which were thought to boost self-esteem and provide adolescents and young adults with refined terminology to use when speaking about mental health. School curriculum requires life skills training that includes some mental health topics, like fostering self-esteem. This knowledge may help young people to cope or to be able to better communicate when they are unwell.

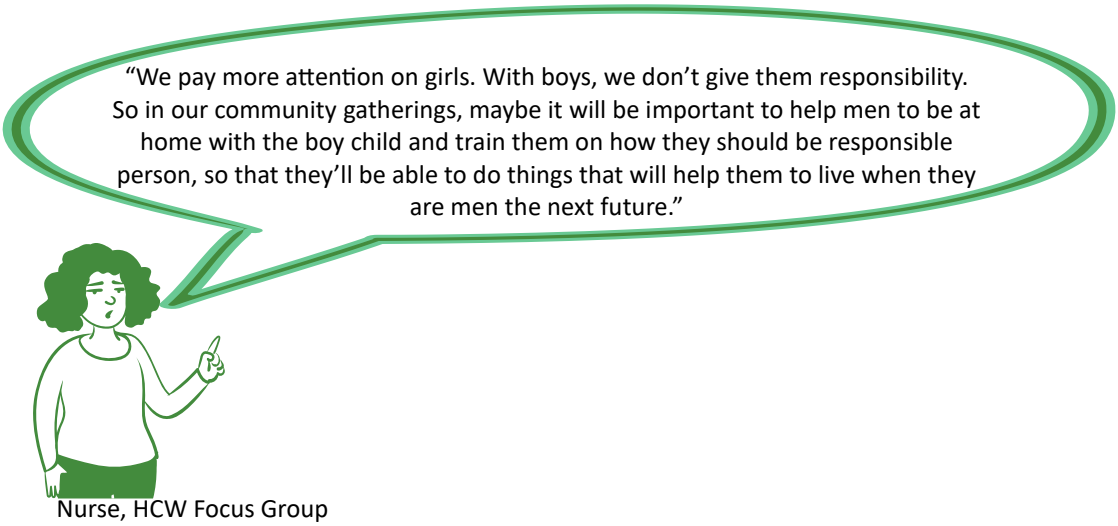
Finally, as noted in the quote above from the underemployed community member, youth in Lesotho do use negative coping when faced with adversities. The negative coping strategies, such as alcohol and substance use, can themselves become adversities:



Peer Educator, Community Focus Group

Interpersonal/Family resilience

At the interpersonal level, participants mainly identified social support and education as resilience resources to support adolescents and young adults. Social support could come from friends or family. Caregivers and other adults in particular were seen to provide structure, advice, and informal forms of education. Participants felt that this guidance from trusted adults could be further leveraged and recommended that parents be provided with education on child development and fostering healthy relationships with their children. Parents or caregivers could then apply this education to improve relationships with their children and offer further guidance. Family education could also include supporting parents and caregivers through separations, divorce, and the integration of blended families. Interestingly, some participants felt that providing parental guidance was particularly important across gender lines:

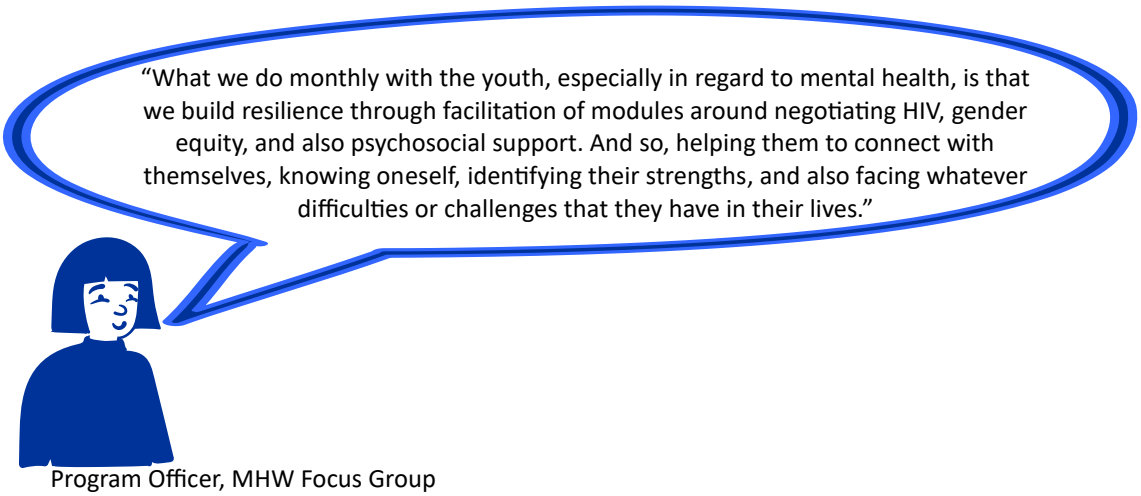


Nurse, HCW Focus Group

Community resilience

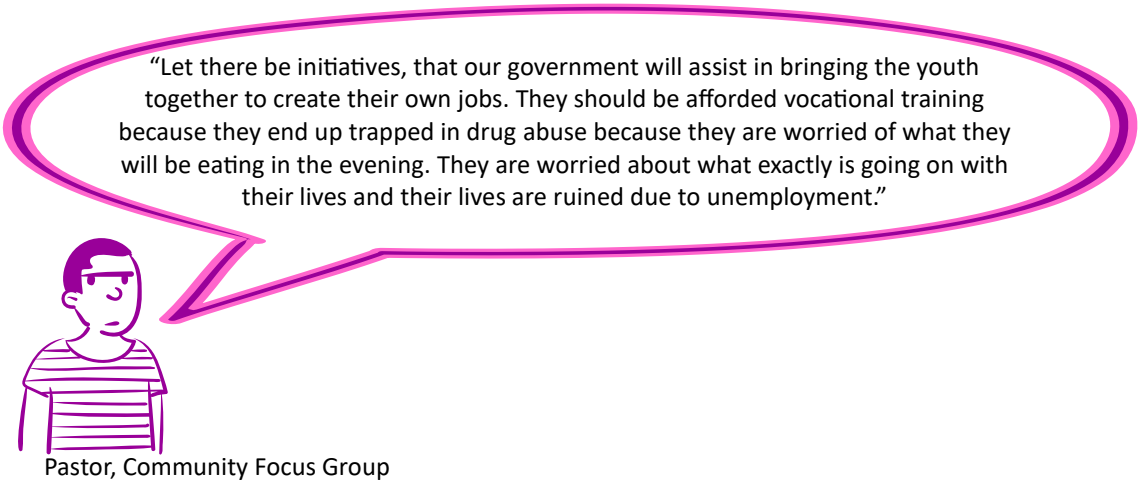
Social support can also be offered at the community level. Multiple participants mentioned counseling being available in their communities, in mental health outpatient treatment units (MOTUs) or adolescent corners at hospitals or through local organizations. Private counselors are more readily available in Maseru and peri-urban settings, though their services are not free. Teen clubs were also available, though many participants mentioned these were directed towards HIV-positive youth. The teen clubs provide group social support, where many youths can interact and provide one another with support. Group social support can also occur through sports, and many participants recommended improving access to playgrounds and other social spaces for adolescents and young adults. Local organizations and MOTUs also

offer support through life skills and mental health training in schools or during after school programs:



Program Officer, MHW Focus Group

Some local organizations also provide career guidance or secondary needs like food and school uniforms, though mainly for HIV-positive youth. Education at secondary and tertiary schools provide additional resources, by capacitating youth for careers but also by protecting youth from risky behaviors. Participants felt that these resources should be expanded to further capacitate lay counselors or ART counselors to provide basic youth mental health support services. Multiple stakeholders could also collaborate to provide both mental health counseling and career guidance. Career guidance, income-generating activity training, and vocational training were among the most common recommendations for improving mental wellbeing amongst this age group. Youth need more opportunities for employment and financial independence:

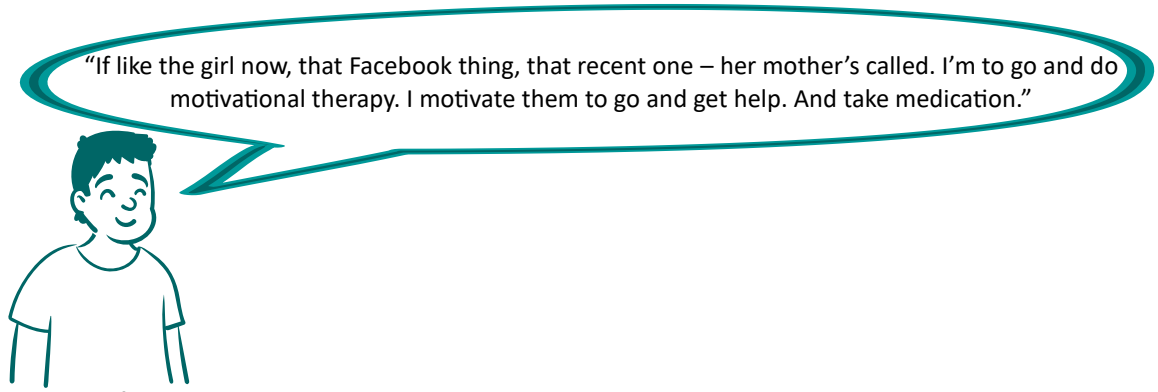


Pastor, Community Focus Group

Another common recommendation was the inclusion of counselors in schools, who could provide basic mental health services and coordinate care with parents and mental health providers in the health system when needed. Finally, participants felt that community involvement in adolescent wellbeing should include training local leaders like chiefs in identifying mental health challenges and encouraging mental wellbeing in their communities.

National/Global resilience

Globally and nationally, social media was viewed by participants positively when it could be used to advocate for mental health. Participants employed in mental health sectors mentioned using various platforms to advertise mental health services like counseling and therapy. Mental health advocacy groups in Lesotho are using social media to raise awareness and promote education about mental health, and also to advertise how people who need mental health services can access them:



Head of Mission, Community Focus Group

Lastly, participants suggested that national initiatives aimed at providing entrepreneurships, internships, and vocational and income-generating training for youth should be expanded, and that youth should be given greater voice in government decisions, through the revitalization of youth participatory forums like youth parliament.

5.3 Moving forward: improving care for adolescent and young adult mental health

Participants were able to identify many adversities faced by adolescents and young adults, as well as many signs and symptoms that young people may be struggling. The ability to identify symptoms of mental health challenges is particularly important in this age group because 50% of mental health disorders present as early as 15 years of age, and 70% of mental health disorders are diagnosed by the age of 25[24] . Additionally, Lesotho has one of the highest suicide rates in the world[11], and participants identified suicide as a challenge within this age group. Suicide is correlated with mental health conditions such as depression and anxiety[25], and so early recognition of mental health challenges in youth may facilitate early treatment and suicide prevention. While participants were able to identify symptoms of mental health challenges, they also noted knowledge as a limitation across generations and within individuals, families, and communities. Further capacitating youth and caregivers regarding

[24] Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Üstün TB. Age of onset of mental disorders: a review of recent literature. Current opinion in psychiatry. 2007 Jul 1;20(4):359-64.

[25] Nyundo A, Manu A, Regan M, Ismail A, Chukwu A, Dessie Y, Njau T, Kaaya SF, Smith Fawzi MC. Factors associated with depressive symptoms and suicidal ideation and behaviours amongst sub-Saharan African adolescents aged 10-19 years: cross-sectional study. Tropical Medicine & International Health. 2020 Jan;25(1):54-69.

both youth development and its relationship to youth mental health would help young people and their loved ones to be more aware of when youth are struggling, and able to seek help early.

Participants also noted many adversities faced by this age group. These adversities are important because of their immediate and long-term impacts. Abuse, neglect, community violence, and household conflict are adverse childhood events that have been associated with mental health challenges including self-harm, suicidal behavior, psychological distress, substance use, and violence perpetration, based on data from Lesotho's Violence Against Children Survey[26,27]. Childhood adversity can affect physiological development such as hormone regulation, brain wiring, and expression of DNA, that can have lifelong impacts[22]. Adverse childhood events (ACEs) have been associated with increased risk of physical[28] and mental health challenges[29] in adulthood, greater instability in relationships and work, and premature death[30]. The impacts of adversity when young can cross generation, through altered genetics, attitudes and beliefs, personal behavior, and relationship skills[21]. As some participants noted above, these adversities do not happen in isolation, and compounded stressors increase risk of adverse outcomes. A recent study using the Violence Against Children Survey data across five African countries, including Lesotho, found that exposure to three or more ACEs increased by eight the odds of becoming a perpetrator of violence. Additionally, males exposed to three or more ACEs were seven times more likely to self-harm or die by suicide[25].

In addition to violence as an adversity, the second major theme noted by the participants was poverty and unemployment. Poverty was observed by the participants to include not just income poverty, but also a lack of access to resources like education and health care. These multidimensional indicators have been found to influence mental health in young people variably across countries, with individual factors like education lag and access to health care more strongly associated with rates of depression than income and employment in some

[26] Picchetti V, Stamatakis C, Annor FB, Massetti GM, Hegle J. Association between lifetime sexual violence victimization and selected health conditions and risk behaviors among 13–24-year-olds in Lesotho: Results from the Violence Against Children and Youth Survey (VACS), 2018. Child abuse & neglect. 2022 Dec 1;134:105916.

[27] Brown C, Nkemjika S, Ratto J, Dube SR, Gilbert L, Chiang L, Picchetti V, Coomer R, Kambona C, McOwen J, Akani B. Adverse childhood experiences and associations with mental health, substance use, and violence perpetration among young adults in sub-Saharan Africa. Child Abuse & Neglect. 2024 Apr 1;150:106524.

[28] Nurius PS, Fleming CM, Brindle E. Life course pathways from adverse childhood experiences to adult physical health: A structural equation model. Journal of Aging and Health. 2019 Feb;31(2):211-30.

[29] Daníelsdóttir HB, Aspelund T, Shen Q, Halldorsdottir T, Jakobsdóttir J, Song H, Lu D, Kuja-Halkola R, Larsson H, Fall K, Magnusson PK. Adverse childhood experiences and adult mental health outcomes. JAMA psychiatry. 2024 Jun 1;81(6):586-94.

[30] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Reprint of: relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. American journal of preventive medicine. 2019 Jun 1;56(6):774-86.

countries[31]. These multidimensional indicators of poverty should be more thoroughly explored in Lesotho, both in relation to their direct impact on mental health conditions such as depression, but also in relation to the relative deprivation that young people are feeling. Participants observed that poverty was related to the disparities that adolescents and young adults perceive between themselves and their peers, when peers have access to food, clothing, phones, etc. that they do not. This sense of undeserved relative deprivation can lead to hostility and poor mental health at an individual level, and discord at a community level[32]. Unemployment not only worsens poverty but can also impact an individual's sense of place in community or hope for the future[33].

Despite the challenges, participants identified resources and recommendations promote resilience in young people in Lesotho. These resources included increasing knowledge about mental health in this age group and in caregivers and communities, further capacitating social support systems by improving communication and awareness in family members, expanding support from community institutions beyond youth living with HIV, and offering more opportunities for skills development, employment, and income generation. Some of these resources are offered in pockets of Lesotho, but improved integration of these resources and dispersal throughout the country will improve mental wellbeing within this age group. Many of these resources could be combined with evidence-based approaches to improving mental wellbeing that have been developed in other countries in sub-Saharan Africa.

One example of a successful youth-targeted intervention in Lesotho is the Nthabi mHealth program, which offers culturally sensitive sexual reproductive health education to young women through a smartphone or tablet application[34]. Though Nthabi modules to date do not specifically include mental health topics, the platform could be expanded to include topics on mental wellbeing promotion, identifying signs and symptoms of mental distress, and locally available resources for someone seeking care, and be made available to both young women and young men. mHealth apps for mental health promotion have been shown to have potential in LMICs[35], where resources often limit inpatient care.

A family-focused intervention, the Parenting for Lifelong Health group program, was developed in South Africa, and has been shown to reduce abuse, improve positive parenting,

[31] Zimmerman A, Lund C, Araya R, Hessel P, Sanchez J, Garman E, Evans-Lacko S, Diaz Y, Avendano-Pabon M. The relationship between multidimensional poverty, income poverty and youth depressive symptoms: cross-sectional evidence from Mexico, South Africa and Colombia. BMJ Global Health. 2022 Jan 1;7(1):e006960.
[32] Walker I, Pettigrew TF. Relative deprivation theory: An overview and conceptual critique. British journal of social psychology. 1984 Nov;23(4):301-10.
[33] Arena AF, Harris M, Mobbs S, Nicolopoulos A, Harvey SB, Deady M. Exploring the lived experience of mental health and coping during unemployment. BMC public health. 2022 Dec 28;22(1):2451.
[34] Nkabane-Nkholongo E, Mpata Mokgatle M, Bickmore T, Julce C, Thompson D, Jack BW. Change in sexual and reproductive health knowledge among young women using the conversational agent "Nthabi" in Lesotho: a clinical trial. BMC Global and Public Health. 2024 Sep 5;2(1):60.
[35] Gama B, Laher S. Self-help: a Systematic Review of the Efficacy of Mental Health Apps for Low-and Middle-Income Communities. Journal of Technology in Behavioral Science. 2023 Nov 11:1-2.

and reduce parent and child substance use in both adolescents and parents[36]. The program also includes a session on financial empowerment. A combination of joint sessions with parent and children, and separate sessions with only parents or only adolescents, can be successfully facilitated from community centers or local organizations, to improve communication and relationships within families.

Another successful intervention in this age group is the Youth Friendship Bench, developed in Zimbabwe, which uses near peer university student interns to deliver a brief psychotherapy in a community setting[37]. Adolescents are empowered with problem-solving and cognitive-behavioral therapy-based coping skills, to better manage challenges in their lives. University students from the National University of Lesotho could be trained as facilitators to deliver this intervention, thereby supporting the mental health of adolescents and capacitating the future generation of mental health providers in Lesotho.

As a final example of interventions for this age group, Farm Radio International is a horizontally integrated youth mental health literacy program developed in Malawi and Tanzania[38]. This intervention used a radio program providing education on mental health as a focal point for discussions of mental health in schools, while capacitating teachers to identify signs of depression in students and refer them to local clinics. This model of education and care prevention improved initial outcomes in depression, and could be adapted to Lesotho, possibly through the life skills curriculum taught in schools, or through mental health outreach with psychiatric nurses.

Beyond these interventions, youth also need to be empowered with employment opportunities that will allow them to generate income and build a sense of community, responsibility, and pride. This could include microlending to allow youth to develop small businesses, funding apprenticeships and internships, or increasing employment opportunities for youth within their communities. Participants suggested the development of playgrounds and other safe spaces for youth to interact; youth could be employed in the planning and development of built spaces, which would provide added benefits of improving mental health within communities as well as for individuals, while also fostering agency in youth as change agents[39]. Youth could also be employed and trained as early childhood educators, providing

[36] Cluver LD, Meinck F, Steinert JI, Shenderovich Y, Doubt J, Romero RH, Lombard CJ, Redfern A, Ward CL, Tsoanyane S, Nzima D. Parenting for Lifelong Health: a pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa. BMJ global health. 2018 Jan 1;3(1):e000539.

[37] Broström S, Johansson BA, Verhey R, Landgren K. "Seeing a Brighter Future"–Experiences of adolescents with common mental disorders receiving the problem-solving therapy "Youth Friendship Bench" in Zimbabwe. Issues in Mental Health Nursing. 2021 Nov 2;42(11):1019-29.

[38] Kutcher S, Perkins K, Gilberds H, Udedi M, Ubuguyu O, Njau T, Chapota R, Hashish M. Creating evidence-based youth mental health policy in sub-Saharan Africa: A description of the integrated approach to addressing the issue of youth depression in Malawi and Tanzania. Frontiers in psychiatry. 2019 Aug 28;10:542.

[39] Mizen A, Fry R, Williams S, John A. Building policy around the built environment for adolescent mental health. The Lancet Child & Adolescent Health. 2024 Nov 26.

cross-generational benefits of addressing the need for youth employment and greater access to preschool for young children[40].

The above initiatives are not an exhaustive list, but provide examples of family, community, and integrated interventions that may be adaptable in the Lesotho context (Figure 10). Additionally, multiple initiatives can be adopted simultaneously. To address the identified need for more education related to mental health, universal prevention and promotion programs could be introduced in schools and communities. To support youth identified as at-risk, targeted initiatives could empower these young people – and possibly their families – with coping strategies and resources to prevent the development of mental health conditions, or to intervene early. Indicated interventions can provide services for young people showing symptoms of mental distress, before a condition fully develops. And treatment should be made available within communities, for young people diagnosed with mental health conditions.

Providing prevention and early interventions as well as treatment strategies will reduce strain on the limited mental health resources available to adolescents and young adults in most communities in Lesotho, while addressing the currently unmet needs of these youth.

Summary

- Adolescents and young adults are struggling with their mental health, which manifests in social, emotional, cognitive, behavioral, and physical changes
- Adversities affecting mental health in adolescents and young adults include interpersonal conflict, neglect, and poverty and unemployment
- Adolescent mental health experts should be trained and employed, to better support youth mental health
- Resources should be expanded to help all struggling adolescents and young adults
- Existing resources can be paired with evidence-based interventions, to provide expanded care

[40] Yousafzai AK, Siyal S, Franchett EE, Dai Q, Rehmani K, Sudfeld CR, Bhamani S, Hakro S, Reyes CR, Fink G, Ponguta LA. Effect of a youth-led early childhood care and education programme on children's development and learning in rural Sindh, Pakistan (LEAPS): a stepped-wedge cluster-randomised implementation trial. The Lancet Child & Adolescent Health. 2024 Dec 2.

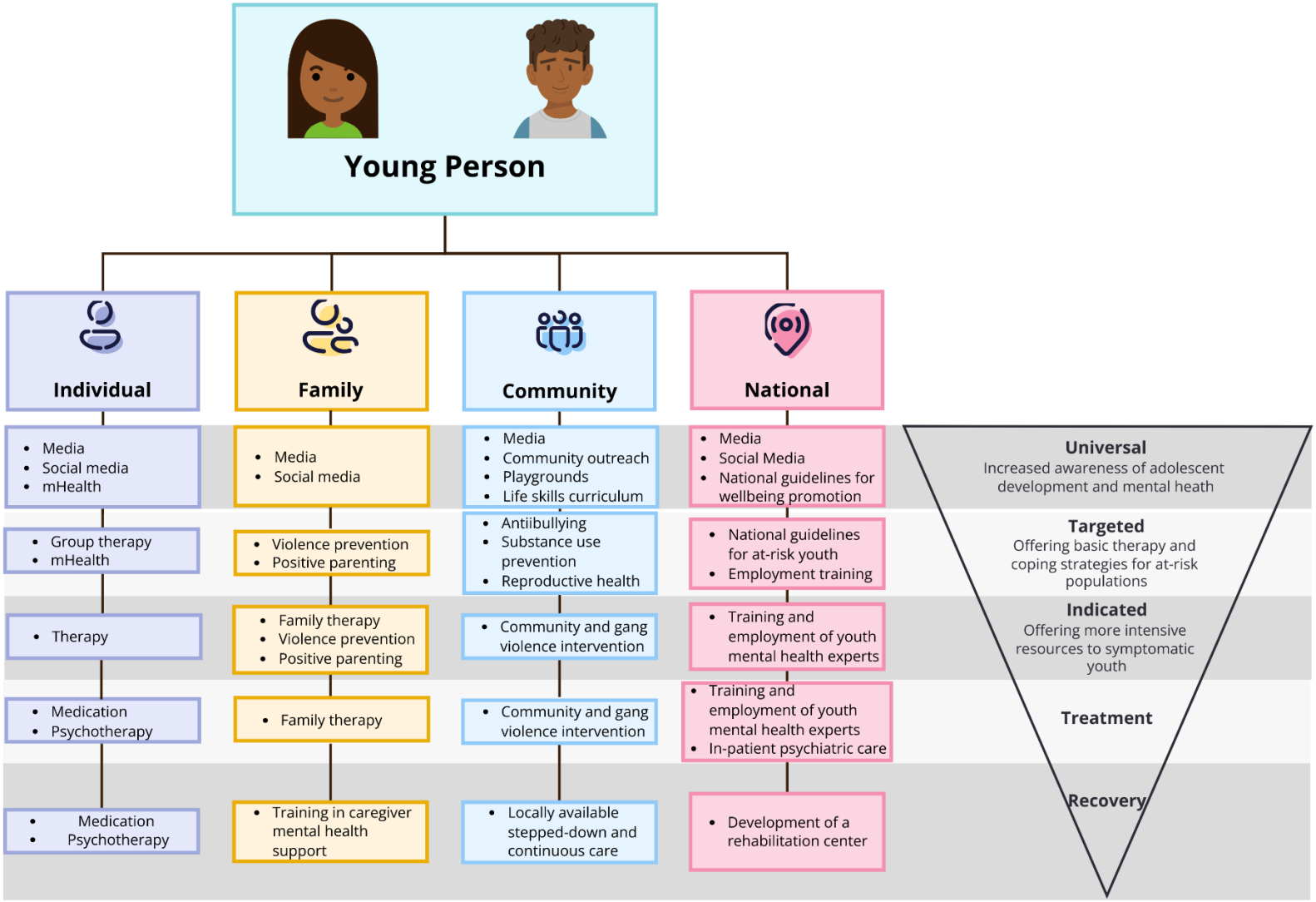


Figure 10: A model for the provision of adolescent mental health promotion, prevention, and intervention

SECTION 6: MENTAL HEALTH IN ADULTS AND OLDER PEOPLE

6.1 Signs and symptoms of mental distress in adults and older people

When asked to identify signs and symptoms that adults and older people may be struggling with their mental health, participants identified behavioral, cognitive, emotional, social, and physical indicators (Figures 11 and 12):

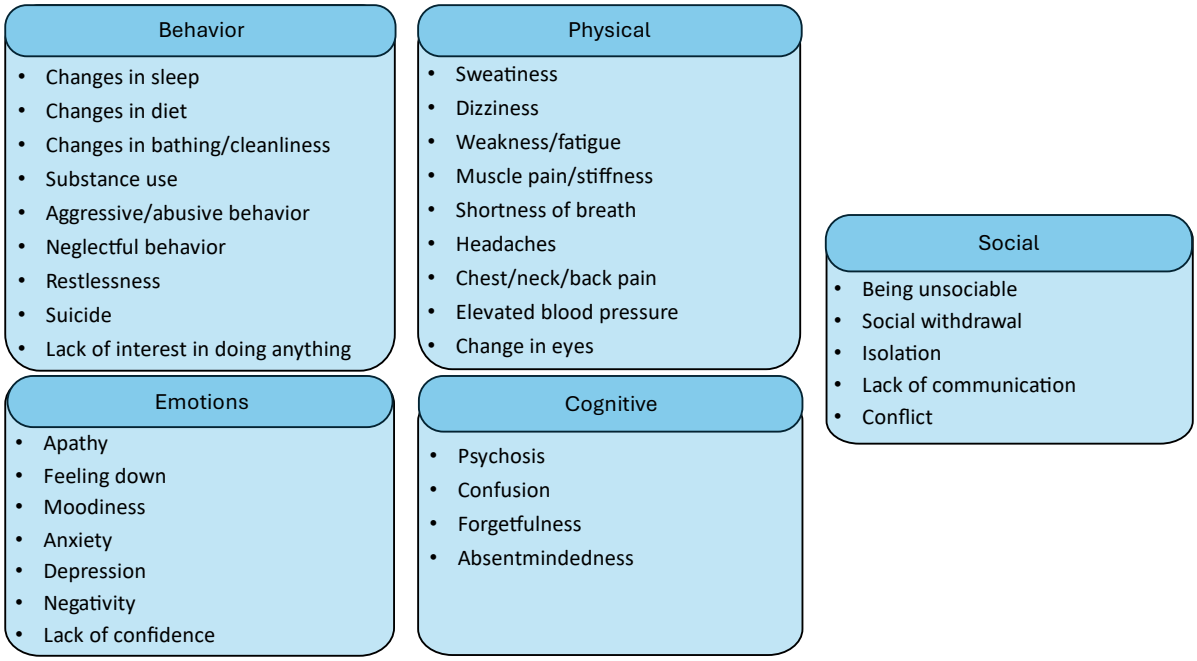


Figure 11: Signs and symptoms of mental distress in adults

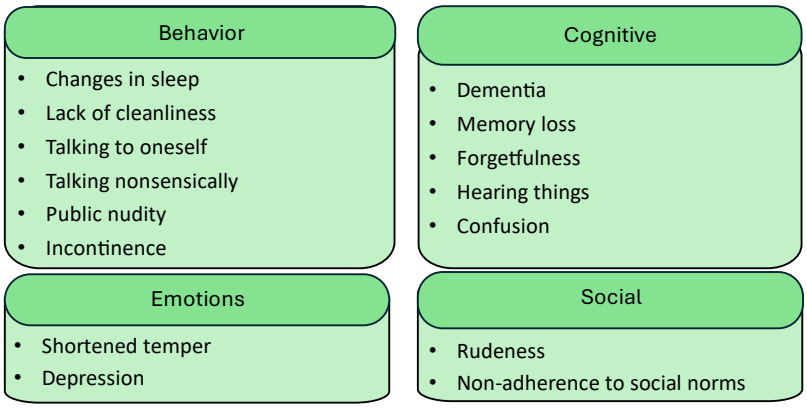
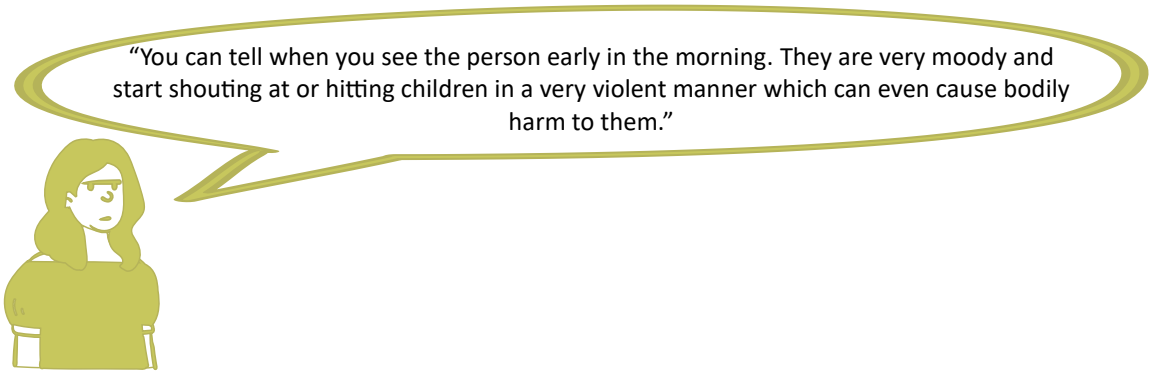


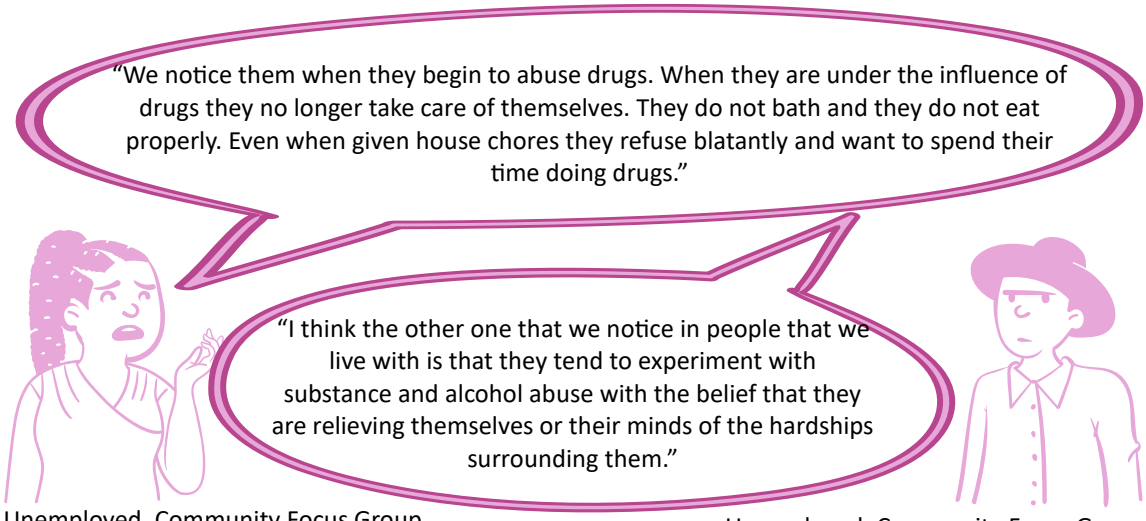
Figure 12: Signs and symptoms of mental distress in older adults

Many participants indicated changes in mood were a sign of mental distress. These changes could include feeling down, but also irritation and moodiness at work or at home, which in its extreme was connected with interpersonal conflict such as abandonment of family, gender-based violence, inter-partner violence, and aggression with children:



Unemployed, Community Focus Group

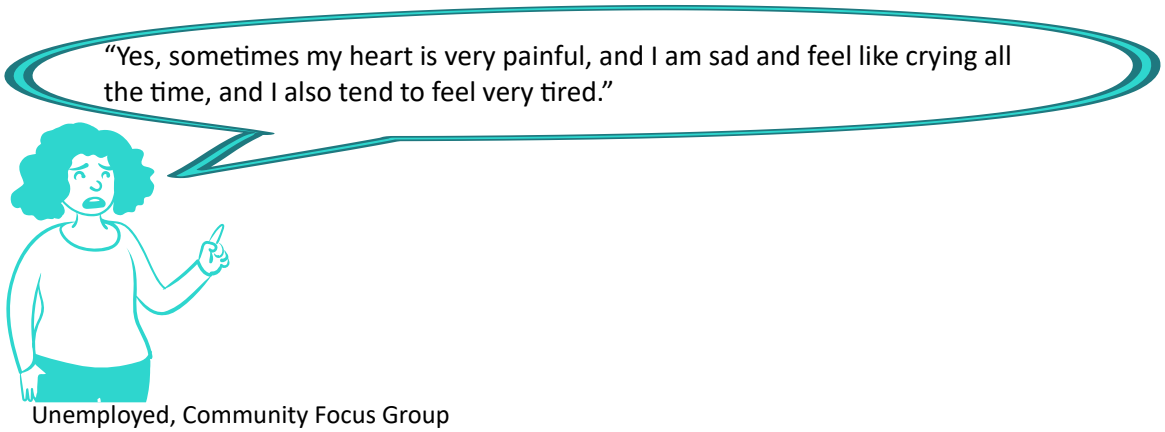
Participants also commonly associated substance use with mental distress:



Unemployed, Community Focus Group

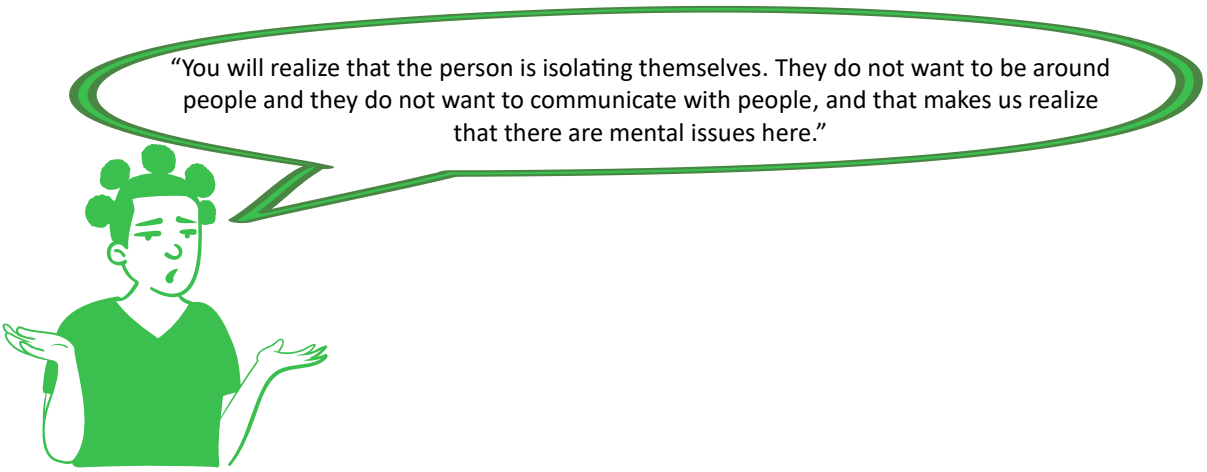
Unemployed, Community Focus Group

One of the participants in the above quotes identified self-care activities like bathing and diet, in addition to substance use. Changes in cleanliness were mentioned in multiple focus groups. Additionally, participants across focus groups identified physical indicators of mental distress, most commonly pain – particularly in the back and chest – and fatigue:



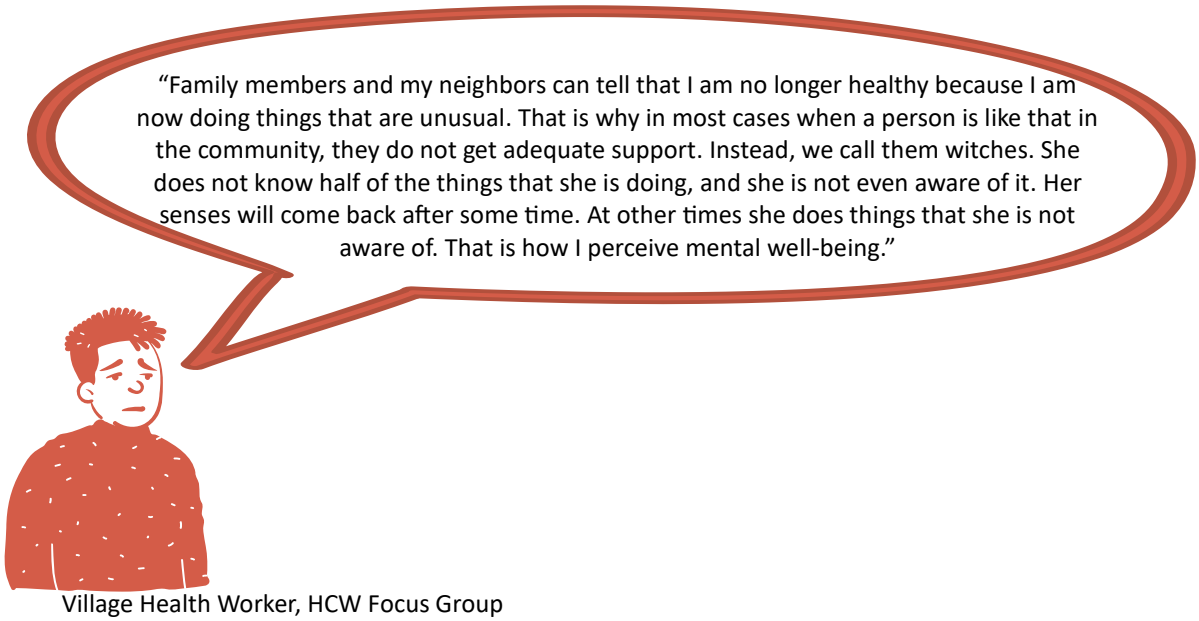
Unemployed, Community Focus Group

Finally, cognitive changes like absentmindedness, and social changes – most commonly isolation and social withdrawal, in addition to conflict – were identified as signs that an adult may be mentally unwell:



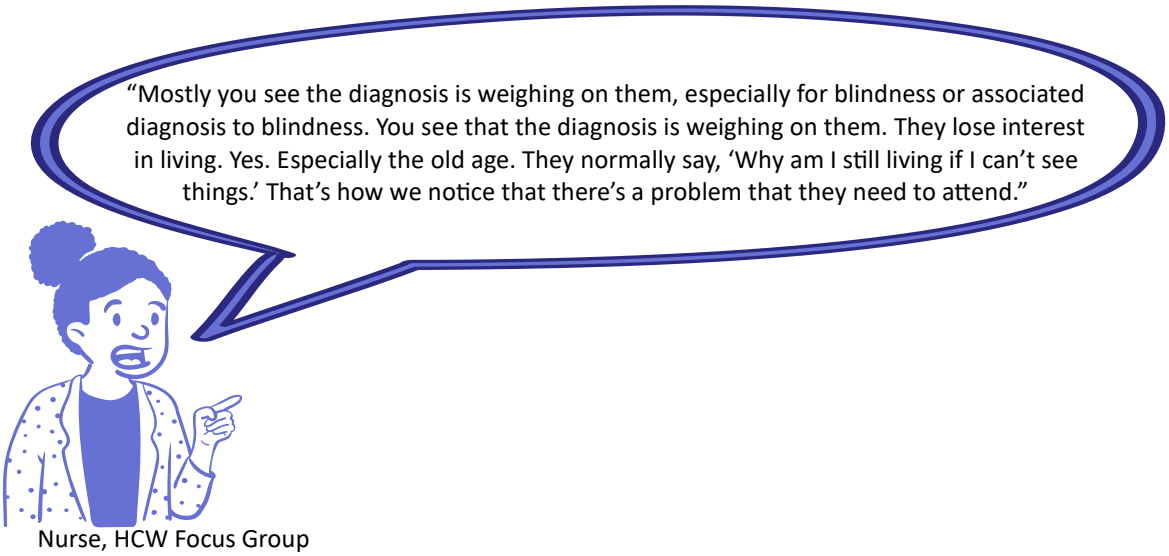
Part-time Lecturer, Community Focus Group

Regarding older adults, cognitive challenges associated with aging were commonly identified as associated with mental distress. These cognitive signs included dementia, memory loss, forgetfulness, and confusion, which were understood to effect interactions between older people and their communities:



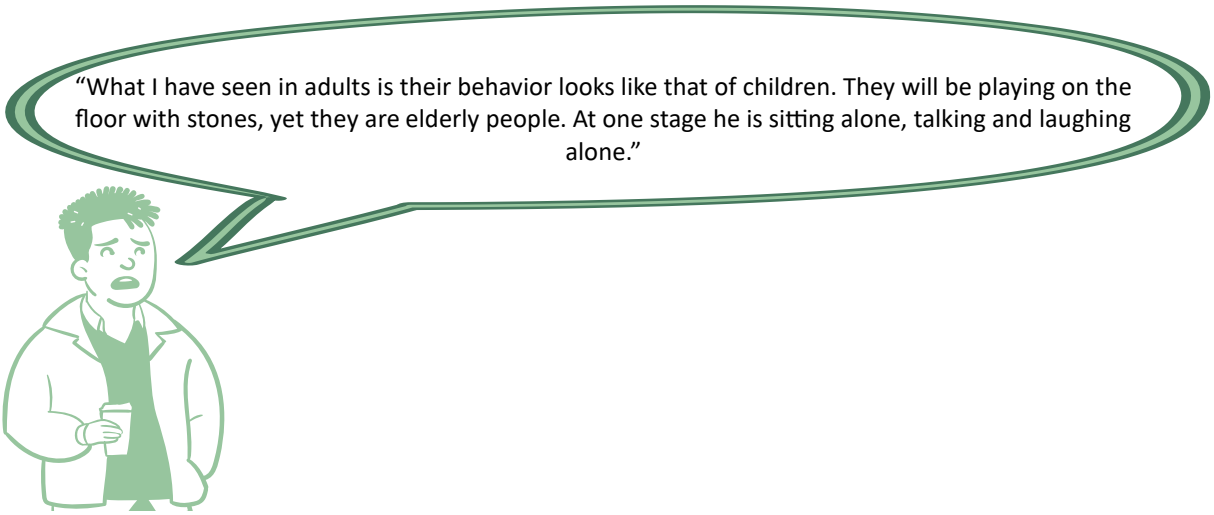
Village Health Worker, HCW Focus Group

Other health workers observed that their older patients displayed signs of depression, which the health workers associated with decline in physical health:



Nurse, HCW Focus Group

Finally, social and behavioral changes were noted by participants, which may again influence mental wellbeing through changes in interpersonal interactions and an older person's interpretation of the world around them:



Unemployed, Community Focus Group

6.2 Adversity and resilience in adults and older people

Participants identified adversities and resilience resources faced by adults and older people across individual, interpersonal/family, community, and national/global levels (Figures 13 and 14):

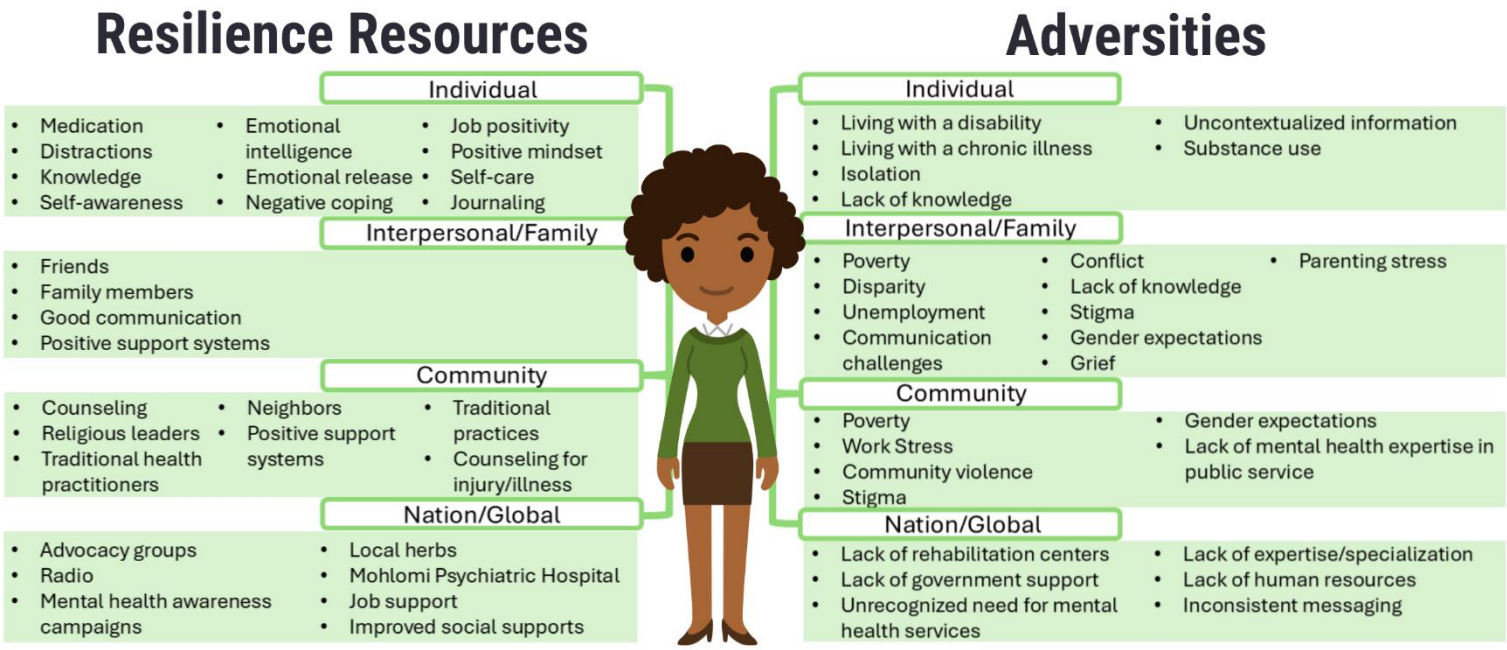
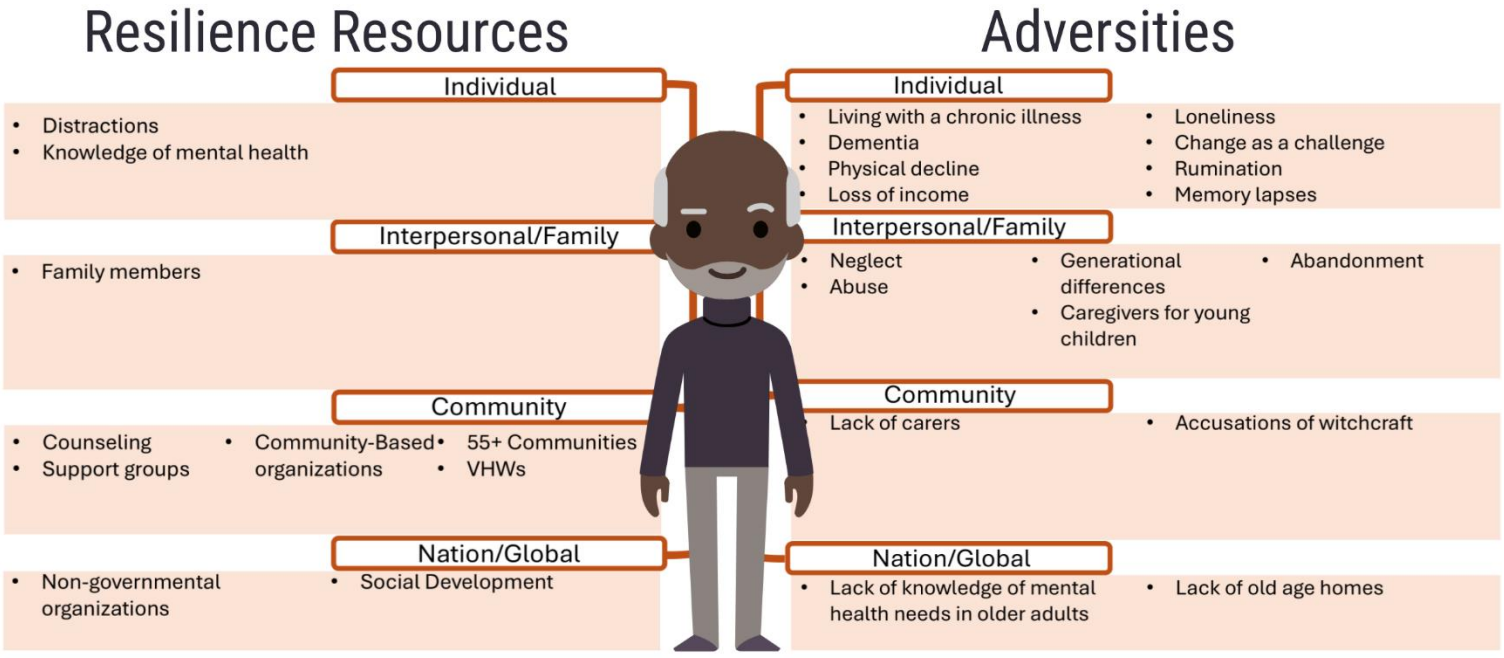


Figure 13: Adversity and resilience resources in adults



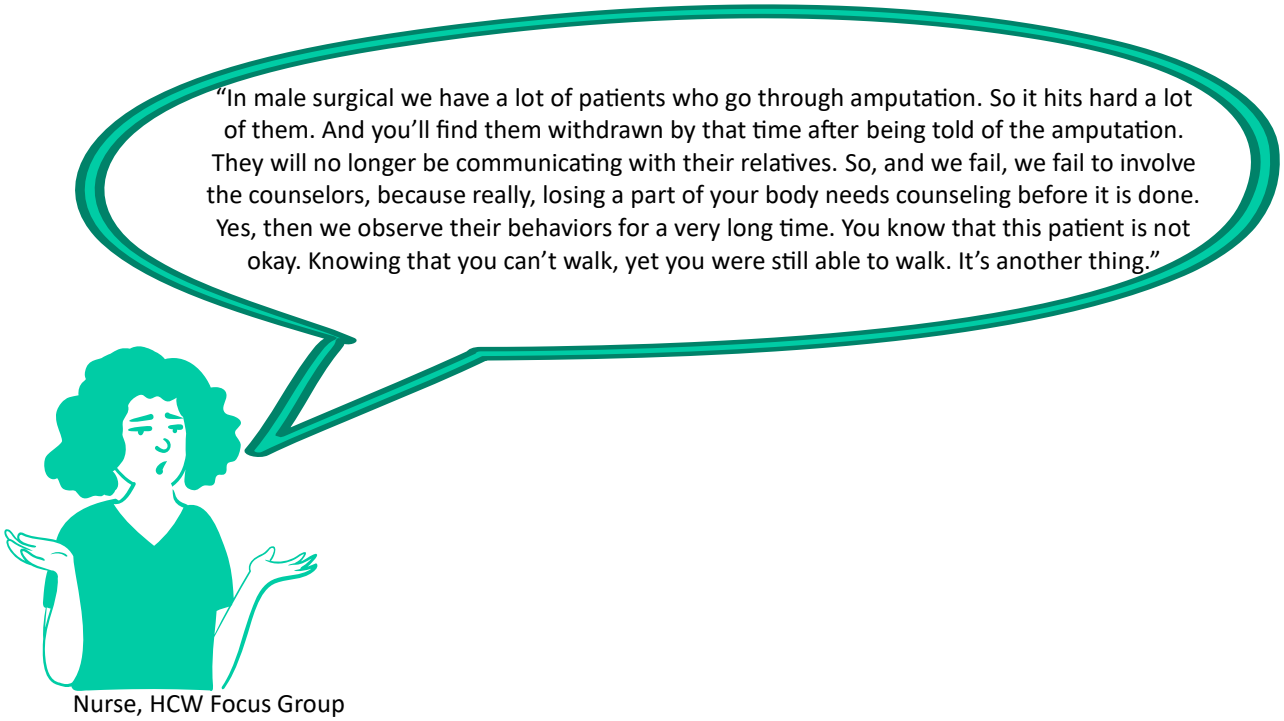
Older people mental health influences

Figure 14: Adversity and resilience resources in older people

6.2.1 Adversity in adults and older people

Individual adversity – adults

Individually, chronic illnesses and disabilities were identified as adversities affecting mental health. This can include inconsistent use of medication or poor adherence due to access or stigma, which can exacerbate mental and physical health concerns. Participants also noted that being born with a disability could increase stigma associated with being disabled, thereby contributing to mental distress through judgement and increased isolation. Additionally, disabilities like amputations or illnesses resulting in chronic conditions like renal failure, can result in long hospital stays followed by challenges in transitioning to new realities:



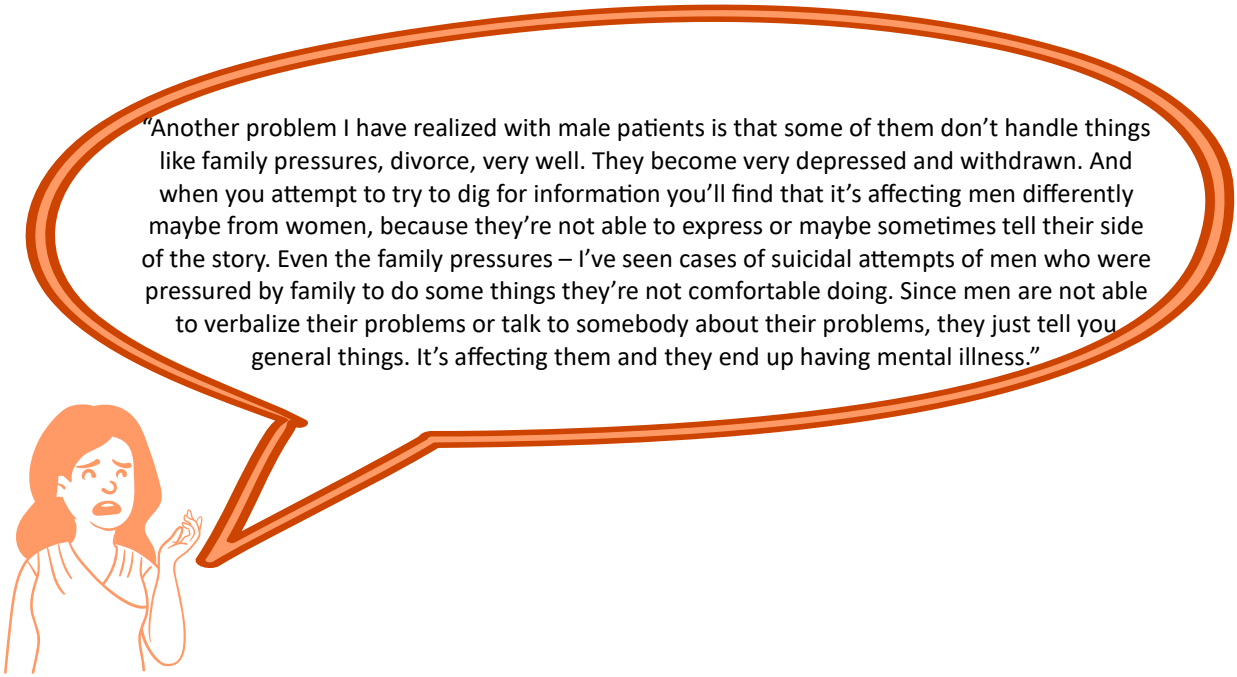
Nurse, HCW Focus Group

A lack of knowledge about mental health, as well as misinformation, were also perceived as adversities which could worsen stigma, limit help-seeking behaviors, or result in faulty conclusions regarding the reasons for individual behaviors. Finally, substance use, particularly alcohol and marijuana, was viewed both as a symptom of mental distress and as an adversity contributing to worsening mental health. Substance use was also noted in some instance to decrease self-care, affect fulfilment of responsibilities at work and at home, and increase interpersonal conflict.

Interpersonal/Family adversity – adults

Interpersonally, family disputes and disagreements with work colleagues were considered major sources of adversity. This conflict could include physical and emotional abuse, including gender-based or inter-partner violence, but could also include stress related to dating, early marriage, and single parenting. Stress related to parenting was generally viewed as an adversity impacting mental health in adulthood. Separation, divorce, and family abandonment contribute to interpersonal stress within families. Interpersonal conflict could

be related to difficulties in communicating between individuals but could also be the result of gendered norms. For example, participants noted that emotional expression or admission of life challenges could be seen as "unmanly." As such, boys and men may be less likely to be taught to express themselves or seek help when they need is, compounding pressures like poverty, unemployment, and interpersonal conflict:



Nurse, HCW Focus Group

Gender identity and sexual orientation were also associated with mental distress, as these minority populations tend to be stigmatized and marginalized. Another form of stigma is related to judgement of individuals suffering post-partum depression, which some participants felt was treated by older generations as attention-seeking. Finally, participants noted bereavement from loss of loved ones to be an adversity within this age group.

Community adversity – adults

Employed adults often face work stress. Some participants noted discrimination at work, particularly by gender or ability. Poor working environments could lead to low mood and lowered quality of work and service provision. This was particularly noted in the healthcare workforce, as many of the focus group participants work in health care. Low salaries were also identified in a number of professions, as impacting mental health. Participants also felt that they internalized stress at work and carried it to other domains of their lives, so that work stress impacted relationships with friends and family.

Additionally, participants identified community-level poverty and community violence as impacting mental wellbeing. Community violence was a particular problem in certain parts of the country, and affected community members discussed being fearful and distressed by gang

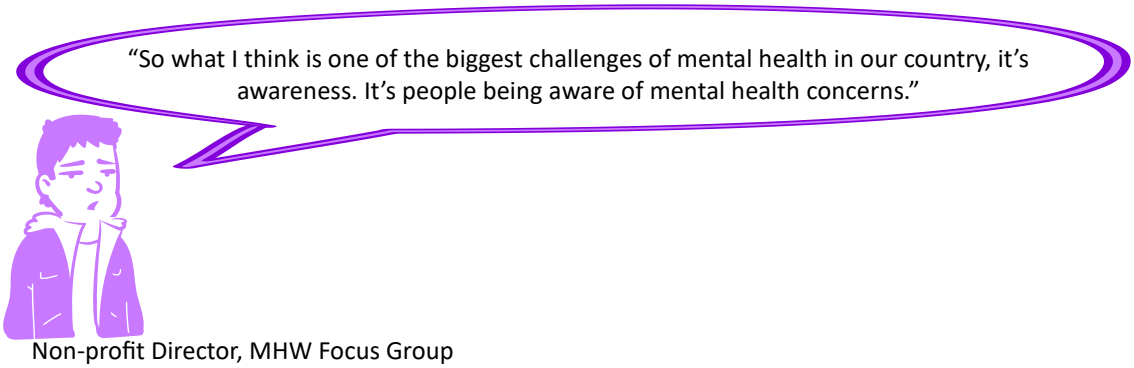
activity of young people in their communities, which was perceived to be a consequence of jealousy and wealth disparity, amongst other reasons:

The above conversation from one focus group highlights the fear, distress, and at times hopelessness that some participants felt regarding the ongoing gang violence in their communities. Also notable in this conversation is the recognition of the cyclical and intergenerational impact of violence, expressed as family members avenging one another and as younger generations being molded to violence by their elders. This community distress extended to health workers in the communities, who expressed fear that rival gangs could seek vengeance if they treated a victim of the gang violence. As one nurse put it, "We often experience intimidation and as a result we are not feeling free" (HCW focus group). Health

care workers are also tending to the injured and bereaved after a death by community violence, which highlights another adversity mentioned in focus groups across Lesotho: the lack of community-based mental health expertise. Not all health centers had counselors, and most counselors at health centers were employed primarily to focus on HIV-related care. Health centers might be able to consult with psychiatric nurses at hospitals but focus group participants felt that these phone consultations were inadequate to their needs and the needs of the patients.

National/Global adversities – adults

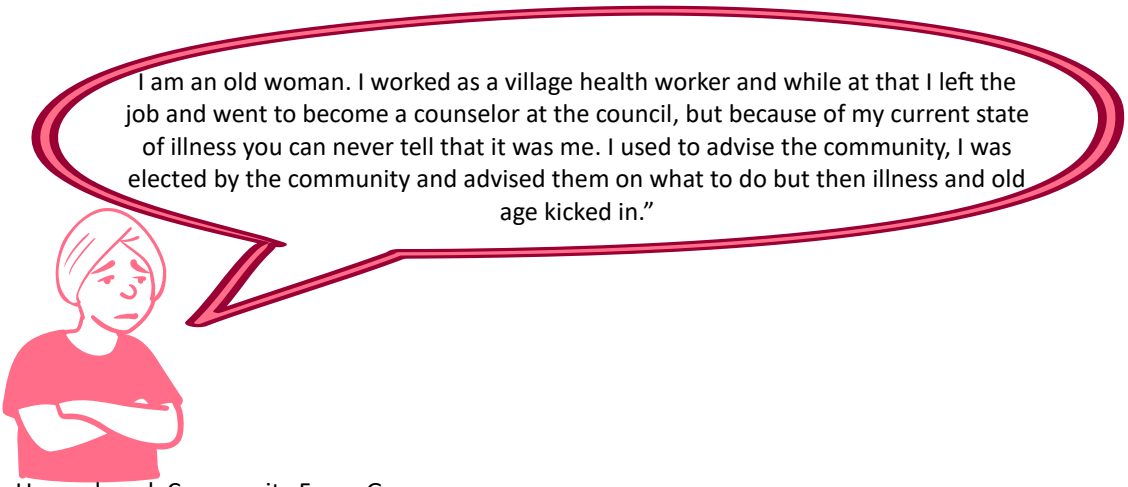
Nationally, participants felt that there was a lack of government support for mental health initiatives and care, which was reflected in the lack of human resources as well as the lack of rehabilitation centers for substance use. Participants felt there were not enough individuals employed in mental health fields, as well as a lack of specialists in mental health related fields. Participants noted a lack of psychiatrists in the country, as well as child psychiatrists, child psychologists, psychiatric social workers, clinical psychologists, and occupational therapists, amongst others. This lack of prioritization of mental health was viewed by some participants as a reflection of the unrecognized need for mental health care, from the government as well as within communities:



Non-profit Director, MHW Focus Group

Individual adversity – older people

Turning to adversities for older people, dementia was often mentioned as both an individual challenge and an interpersonal one. Dementia was associated with confusion and disorientation, as well as memory lapses and forgetfulness. Participants also noted physical decline and chronic illnesses that can come with age and present major life changes and challenges:

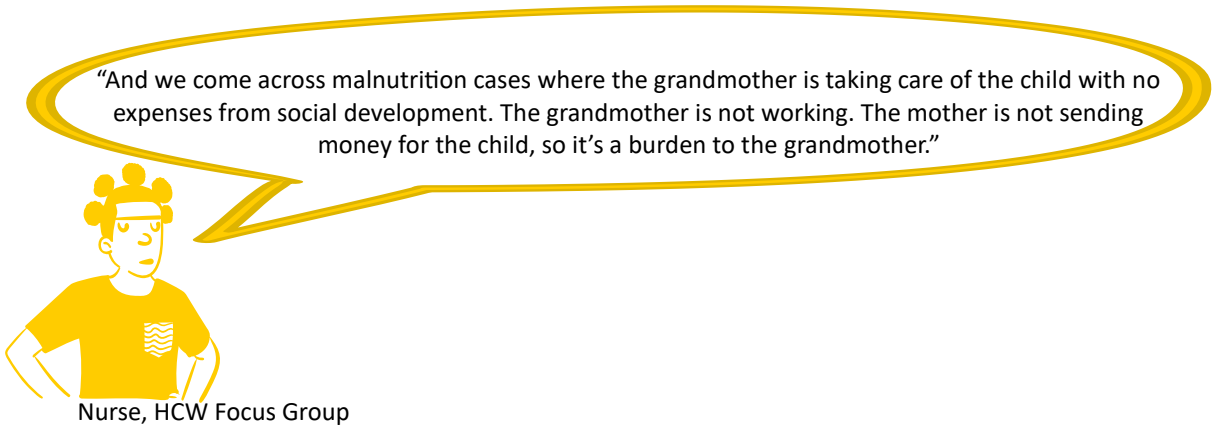


Unemployed, Community Focus Group

Related to the above quote, older age was identified with a loss of income as well. Finally, older people were perceived to sometimes be lonely as family moved for work and friends passed away, leaving them more isolated and prone to rumination.

Interpersonal/Family adversity - older people

Multiple forms of elder maltreatment were recognized by participants. Sexual abuse was mentioned by some. Others noted financial abuse or theft; pensions could be taken by relatives. Most commonly, physical abuse and even occasionally homicide were mentioned. Physical abuse could be related to dementia, the symptoms of which may be interpreted as witchcraft. Family challenges could also take the form of neglect or abandonment, or of intergenerational differences that lead to conflict. Many older people, particularly women, are caring for their grandchildren:

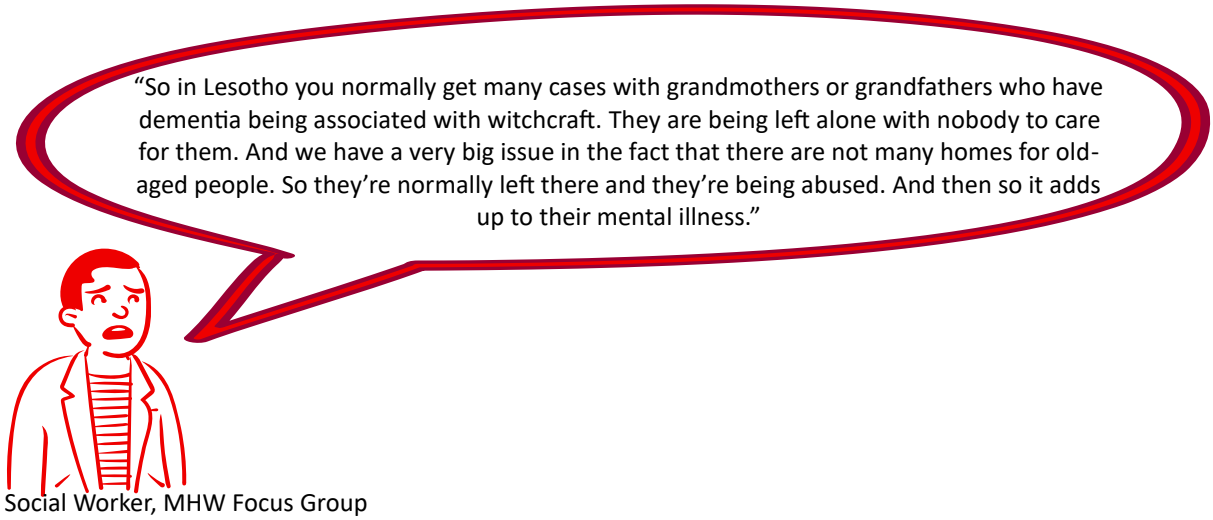


Nurse, HCW Focus Group

Community adversity - older people

Within communities, participants mainly identified two adversities affecting older people. The first is a lack of carers or homes for older people. Because it is increasingly common for younger generations to move from home, there are fewer children or grandchildren available to help care for aging loved ones. Additionally, older people sometimes prefer to remain where they have spent most of their lives, even when they have the opportunity to move with their children. Because there are few homes for older people, and few people employed to

care for older people, this can lead them vulnerable to isolation and consequently affect mental health. Mental health may also be affected indirectly, through compromised diet, poor medication adherence to chronic illnesses, and other physical complaints. Because accusations of witchcraft may also come within communities, being alone with no carers may also leave older people vulnerable to abuse:



Social Worker, MHW Focus Group

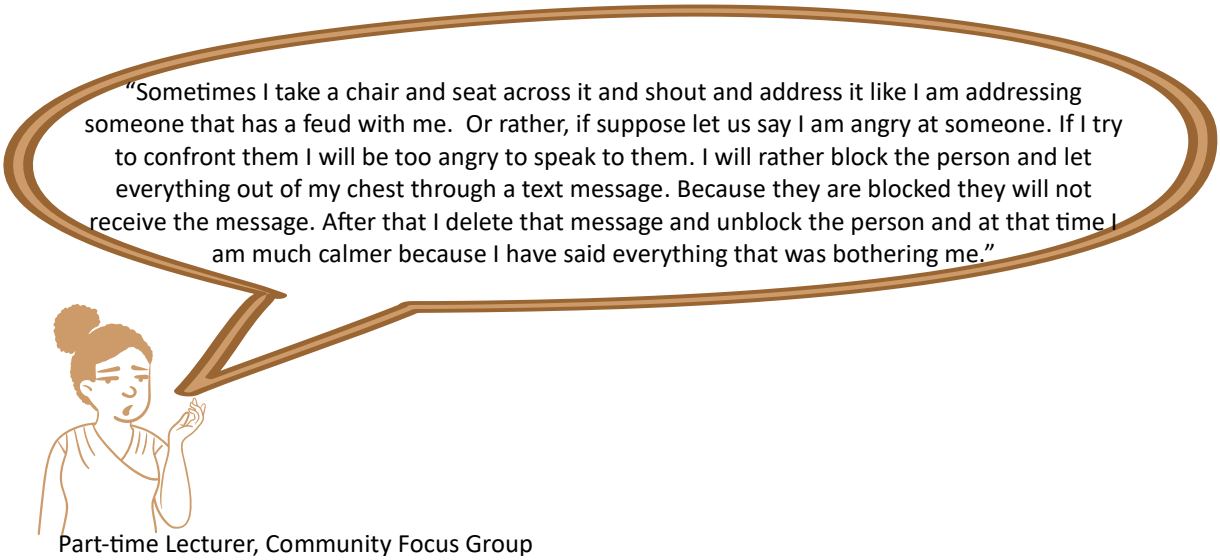
National/Global adversities - older people

Finally, as with other age groups, participants identified that there was a lack of knowledge of the mental health needs of older adults. Additionally, the lack of old age homes was viewed as a national policy issue as well as a community issue.

6.2.2 Resilience resources to promote wellbeing and address mental health challenges in adults and older people

Individual resilience – adults

Participants identified many strategies and resources that they use, or that other adults in their lives use, to support mental wellbeing. One domain of coping that was discussed was self-care, which included maintaining hygiene and daily routines, but also journaling and exercise. Related to self-care, self-awareness, emotional intelligence, and emotional release were also examples provided for maintaining wellbeing. One participant described how she would vent:

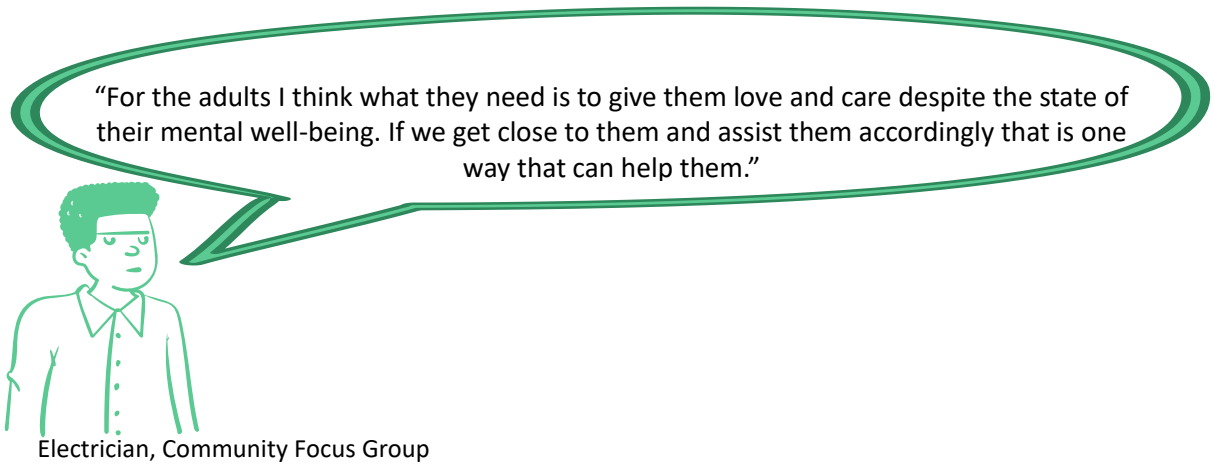


Part-time Lecturer, Community Focus Group

Maintaining a positive mindset was another strategy to promote wellbeing. It was also noted that knowledge could foster wellbeing, and many participants expressed an interest in learning more about mental health, including a desire for access to ongoing education. Some participants had experience with psychiatric medications, either personally or through loved ones, and identified those as a coping strategy. Distractions such as radio programs can also help to alleviate stress or feelings of isolation. Finally, multiple participants discussed negative coping strategies such as alcohol or drug use, that were used in an attempt to relieve stress during difficult times.

Interpersonal/Family resilience – adults

Good communication and positive support systems from family, friends, coworkers, health care providers, and others were the main interpersonal resilience resources identified:

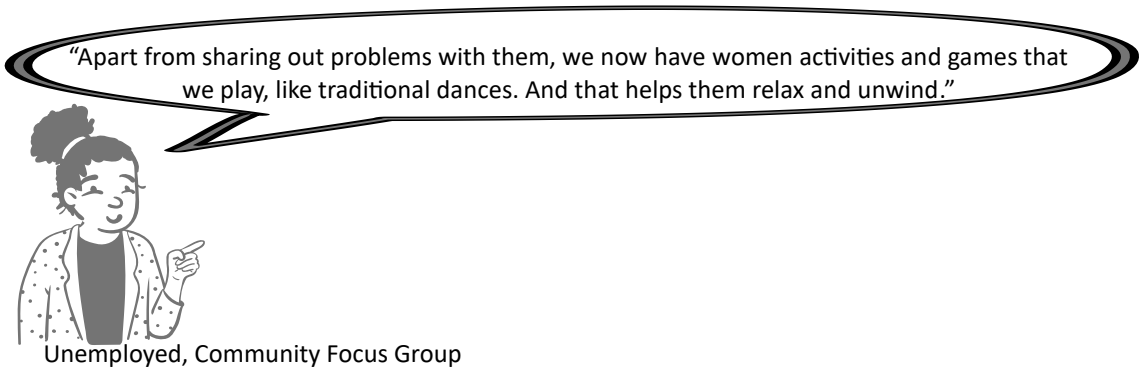


Electrician, Community Focus Group

One participant additionally commented that familial love and responsibility, like needing to care for a child, can motivate an adult to try to care for their health and wellbeing, even when they are struggling.

Community resilience – adults

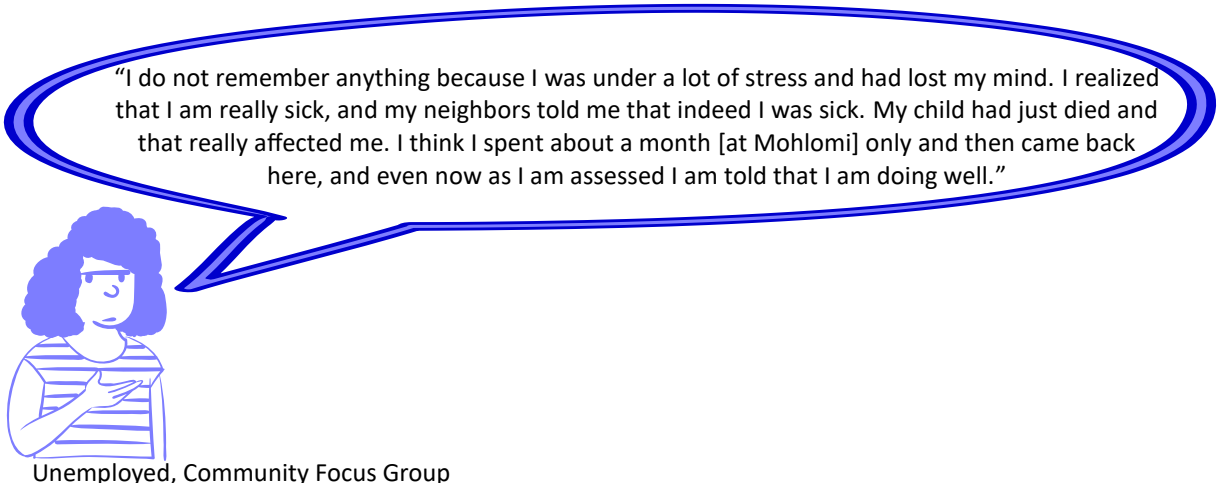
Within communities, counseling available at health centers and hospitals was identified a resilience resource. Local leaders, including religious leaders and traditional health practitioners, were also considered to provide support for emotional wellbeing. Police, non-profit organizations, and social development provide services to support individuals who are struggling financially or who are survivors of violence. Additional mental health support comes through positive relationships with neighbors, support groups, and connection with culture and values:



Unemployed, Community Focus Group

National/Global resilience – adults

Nationally, participants identified advocacy groups and media programming such as radio shows. Mental health awareness campaigns have also been initiated in some communities by the Ministry of Health and Mohlomi Hospital and should be expanded. Mohlomi Hospital was identified as another resource, with some participants disclosing their own narratives of healing:

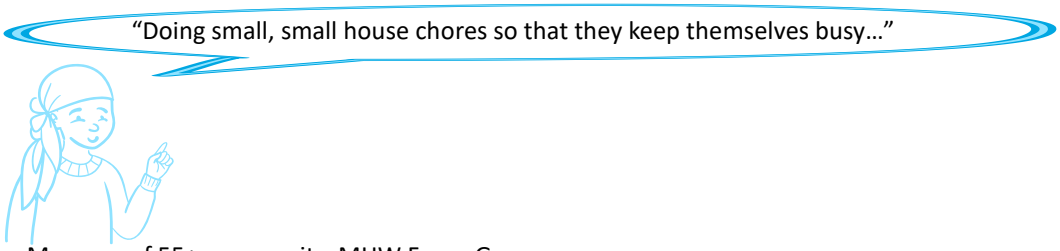


Unemployed, Community Focus Group

A few participants also noted that local herbs such as tabola have traditionally been used to alleviate some mental health concerns. Finally, it was recommended by multiple participants that employment training and be expanded to provide economic relief and decrease stress. Employed participants also recommended the development of employment policies to protect worker rights, prevent workplace discrimination, and provide for wellness programs.

Individual resilience – older people

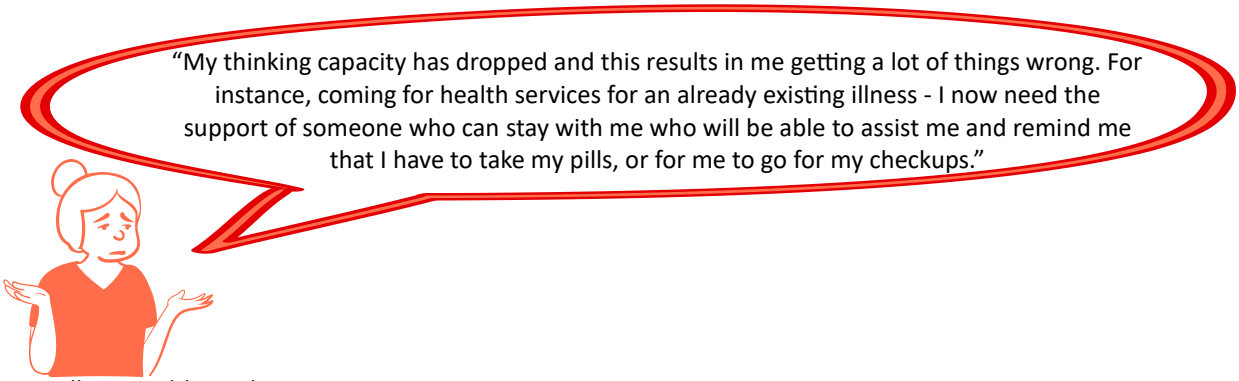
Participants felt that educating older people to increase awareness of mental health within their age groups would help them maintain wellbeing or identify distress early. Activities to keep the mind busy were already being used by some participants:



Manager of 55+ community, MHW Focus Group

Interpersonal/Family resilience - older people

Family members are able to support the wellbeing of older people, by listening as older people told their stories. Additionally, family members support their older loved ones through financial management, ensuring that their parents and grandparents are able to receive their pensions and protecting them from financial theft. Finally, younger generations can offer physical caregiving, such as assistance in bathing, using the toilet, accessing food, and medication adherence:

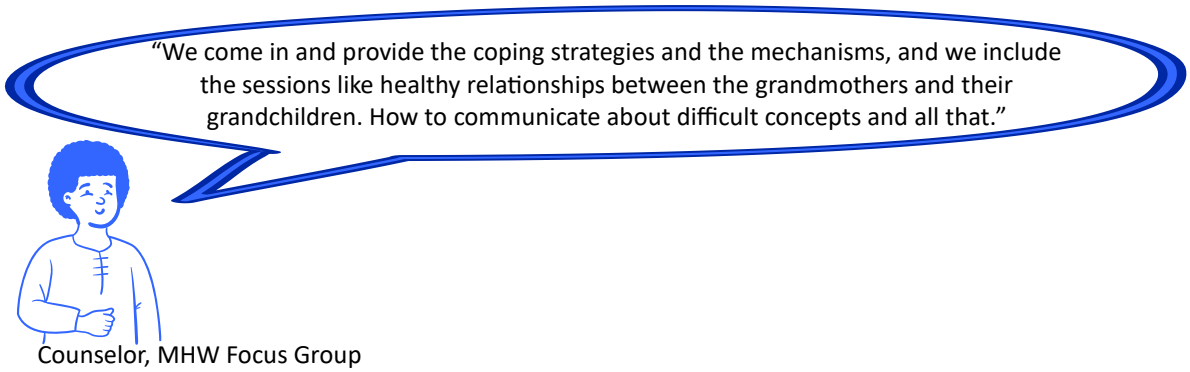


Village Health Worker, HCW Focus Group

Community resilience - older people

Counseling at health facilities was found to be useful for promoting mental wellbeing in older adults. Village health workers also provide counseling and education to families and communities to sensitize individuals of all ages about behaviors changes that can occur in older adulthood, and additional support that can be provided to older adults. Participants recommended further educating professionals working with older adults – such as health workers and care providers – about the mental health needs of older adults. Community-

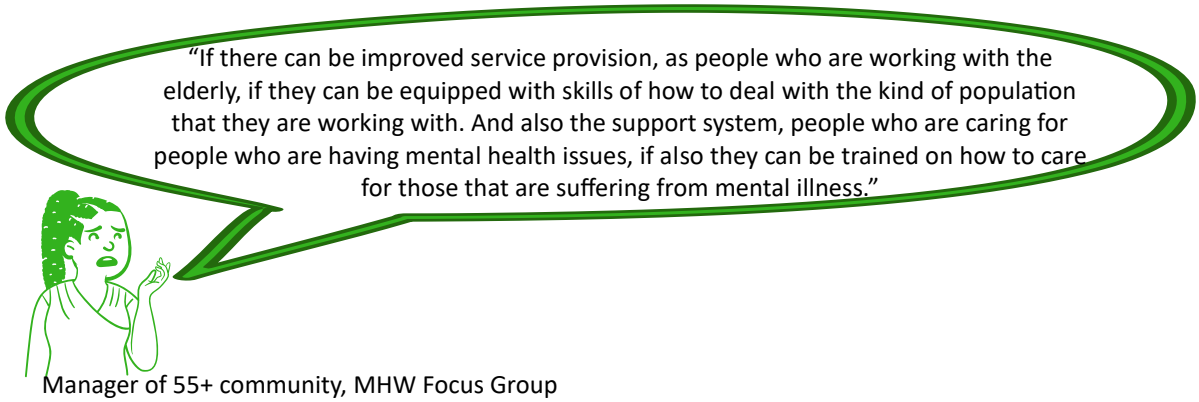
based organizations and support groups exist in some communities, to support older adults or provide psychoeducation and relationship-building workshops between generations:



Counselor, MHW Focus Group

National/Global resilience - older people

Nationally, participants recommended further educating caregivers of older people, health specialists working with older people and social development, to better support the mental wellbeing of older people. Additionally, participants felt that NGOs dedicated to supporting older adults should be expanded and further capacitated to provide mental and physical health resources to older people and their families:



Manager of 55+ community, MHW Focus Group

6.3 Moving forward: improving care for adult and older people's mental health

Participants identified multiple adversities in adulthood and older adulthood. They also noted many common signs and symptoms that adults and older people may be struggling with their mental health. As most of the participants in this study were in early to middle adulthood, it is perhaps unsurprising that they were able to identify and discuss the manifestations of mental distress across behavioral, emotional, cognitive, physical, and social domains. In particular, participants developed a longer list of physical symptoms associated with mental distress in adulthood than in any other stage across the lifespan. The symptoms participants identified are often observed in individuals experiencing depression- or anxiety-related mental health challenges. Participants identified fewer signs and symptoms of mental distress

in older adults, possibly because mental health care needs in older adults tend to be less acknowledged and addressed even within mental health professions[41]. One commonly mentioned sign of mental distress that was mentioned uniquely in older adults was dementia. Other symptoms such as non-adherence to social norms, talking nonsensically, and public nudity, may also be signs of cognitive impairment and were identified only in this age group.

Participants also identified adversities faced within both age groups, many of which were also common to children and youth. These included living with a disability, illness or chronic condition, lack of awareness of mental health, and isolation and loneliness. Loneliness and social isolation in particular have become a focus since the COVID-19 pandemic and are associated with multiple adverse physical and mental health concerns including substance use and suicidality[42,43]. Loneliness and social isolation are higher in people living with mental illness and in older people, which can create a loop whereby worsening health and mental health lead to greater isolation and loneliness and vice versa.

Stigma was also mentioned across the lifespan. Within adults and older adults, stigma – including of people living with mental illness and ageism – can also contribute to loneliness and social isolation[44]. It can affect employment and poverty. Some mental health care workers noted that they had patients who had lost jobs when they mental health status was discovered. This could happen even in former patients who had recovered. In older adults, stigma and misinformation result in behavioral changes being misinterpreted as witchcraft and lead to maltreatment, physical abuse, or homicide.

Poverty and employment were common themes within adulthood, as with adolescents and young adults. As with younger people, relative deprivation creates an added dimension of adversity that lead to mental distress and community discord. One participant quoted above attributed the gang violence in communities in part to wealth disparities. For adults who are employed, discrimination, burnout, and poor working conditions contribute to declines in mental wellbeing.

Family conflict was also identified as an adversity in adults and older adults. Within the adult age group, this conflict could include emotional, physical, or sexual abuse, gender-based violence, or inter-partner violence. It could also include separation or divorce. In both adults and older people, intergenerational conflict was a source of distress. For older people, abuse within families could include financial, physical, or sexual.

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[41] Reynolds 3rd CF, Jeste DV, Sachdev PS, Blazer DG. Mental health care for older adults: recent advances and new directions in clinical practice and research. World Psychiatry. 2022 Oct;21(3):336-63.

[42] World Health Organization. Mental health of older adults [Internet]. World Health Organization. 2023. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

[43] Williams CY, Townson AT, Kapur M, Ferreira AF, Nunn R, Galante J, Phillips V, Gentry S, Usher-Smith JA. Interventions to reduce social isolation and loneliness during COVID-19 physical distancing measures: A rapid systematic review. PloS one. 2021 Feb 17;16(2):e0247139.

[44] de Mendonça Lima CA, Ivbijaro G. Mental health and wellbeing of older people: opportunities and challenges. Mental health in family medicine. 2013 Sep;10(3):125.

A final major theme of adversity in both age groups was a lack of human and other resources to support mental health promotion, prevention, intervention, and treatment efforts. As with other age groups, participants felt that mental health was not well understood or appropriately prioritized within community, district, and national systems. This was reflected in a lack of experts, mental health care centers, rehabilitation centers, research, and government support.

Lesotho does have resources to address some of these individual and socioeconomic determinants of health. Similar to younger age groups, these resources include motivation amongst community members, educators, and health and mental health providers to learn more about mental health and mental health care. Additionally, because individuals impact the mental health of other people within their familial and community orbits, improving communication and awareness of mental health needs could improve mental wellbeing for all ages. Improving education could include not only knowledge of common mental disorders, but promoting skills related to wellbeing – emotional intelligence, self-awareness, self-care, and mindfulness. Leveraging and fostering existing frameworks within communities, such as community-based organizations, village health workers, traditional health practitioners, and religious leaders, could provide a framework for initiating mental health awareness campaigns and education. National leadership such as the Ministry of Health and the Ministry of Education and Training, as well as NGO's, should work together with advocates who already have media and social media platforms, to provide consistent messaging and education from the ground up. Training of mental health professionals in Lesotho should be expanded, to capacitate specialists in needed fields such as psychiatry. Training should also capacitate more professionals in already-existing fields such as psychiatric nursing, social work, counseling, to provide psychotherapy and medication in accordance with best practices. Finally, a rehabilitation center should be established in Lesotho, to provide treatment for those suffering from addiction.

Multiple evidence-based mental health initiatives have been developed in sub-Saharan Africa and around the world. These initiatives should be assessed to determine their adaptability and acceptability within Lesotho's context. One example is Problem Management Plus, which uses psychoeducation, cognitive behavioral methods, and relaxation to improve the mental health of individuals suffering mild-to-moderate distress[45]. Similarly, the Friendship Bench uses cognitive behavioral methods and relaxation[46]. Parenting for Lifelong Health addresses the mental health of caregivers, while also supporting economic empowerment and improved communication and relationships between caregivers and children[18]. The Women's Health

[45] Marchetti M, Ceccarelli C, Muneghina O, Stockner M, Lai C, Mazzoni G. Enhancing Mental Health and Well-being in adults from lower-resource settings: a Mixed-Method evaluation of the Impact of Problem Management Plus. Cambridge Prisms: Global Mental Health. 2024 Jan;11:e56.

[46] Chibanda D, Bowers T, Verhey R, Rusakaniko S, Abas M, Weiss HA, Araya R. The Friendship Bench programme: a cluster randomised controlled trial of a brief psychological intervention for common mental disorders delivered by lay health workers in Zimbabwe. International journal of mental health systems. 2015 Dec;9:1-7.

CoOp teaches adults strategies for violence reduction and improved communication in relationships, while also providing education about substance use and safe sexual practices[47]. Common to all of these interventions is that they can be facilitated by non-mental health experts, thereby allowing for task-shifting in Lesotho's resource-limited setting. Each of these interventions is also multimodal, meaning each utilizes multiple methods (e.g., psychoeducation and cognitive behavioral methods) to enhance skills and improve mental health in participants.

Multimodal interventions tend to be more effective than single-mode interventions[48,49], and any programs initiated in Lesotho should be assessed for the methods they use, as well as acceptability, adaptability, and feasibility within Lesotho's context. This could involve asset-mapping to determine potential local partners for an initiative, as well as utilizing a participatory approach that involves service-users as well as providers in the adoption, adaptation, and implementation of any mental health programming. Group interventions, or interventions that can be adapted to groups, could also be explored. Group interventions are beneficial in that target more people and thus can require fewer resources. They can also bring together individuals with common experiences who can support one another.

Support groups may also serve that function. Within communities or health facilities, support groups could be formed based common background, for example by disease, adversity, or demographic (e.g., post-partum depression in women, amputation in men, loneliness in older people). Beyond these interventions, local and national government can work with communities to develop consistent messaging and campaigns around mental health, and to address mental health concerns such as community violence. Improving mental health and care requires more than a single intervention – it will require sustained effort from individual to national levels, and across private and government sectors.

[47] Wechsberg WM, Ndirangu JW, Speizer IS, Zule WA, Gumula W, Peasant C, Browne FA, Dunlap L. An implementation science protocol of the Women's Health CoOp in healthcare settings in Cape Town, South Africa: A stepped-wedge design. BMC Women's Health. 2017 Dec;17:1-1.

[48]Brasser M, Frühholz S, Schneeberger AR, Ruschetti GG, Schaerli R, Häner M, Studer-Luethi B. A randomized controlled trial study of a multimodal intervention vs. cognitive training to foster cognitive and affective health in older adults. Frontiers in psychology. 2022 Jun 20;13:866613.

[49] Oakes-Cornellissen A, Morton D, Rankin P, Renfrew M. Efficacy of a multimodal lifestyle intervention (The Lift Project) for improving the mental health of individuals with an affective mood disorder living in South Africa. Frontiers in Psychology. 2023 Jan 25;14:1127068.

Summary

- Adults and older people are struggling with their mental health, which manifests in social, emotional, cognitive, behavioral, and physical changes
- Adversities affecting mental health in adults include relationship and intergenerational conflict, work stress, community violence, and poverty and unemployment. Older adults also experience discrimination and violence, as well as intergeneration conflict and illness
- More health experts should be trained and employed across the country
- Existing community-based resources can be paired with evidence-based interventions and government support, to provide sustainable expanded care

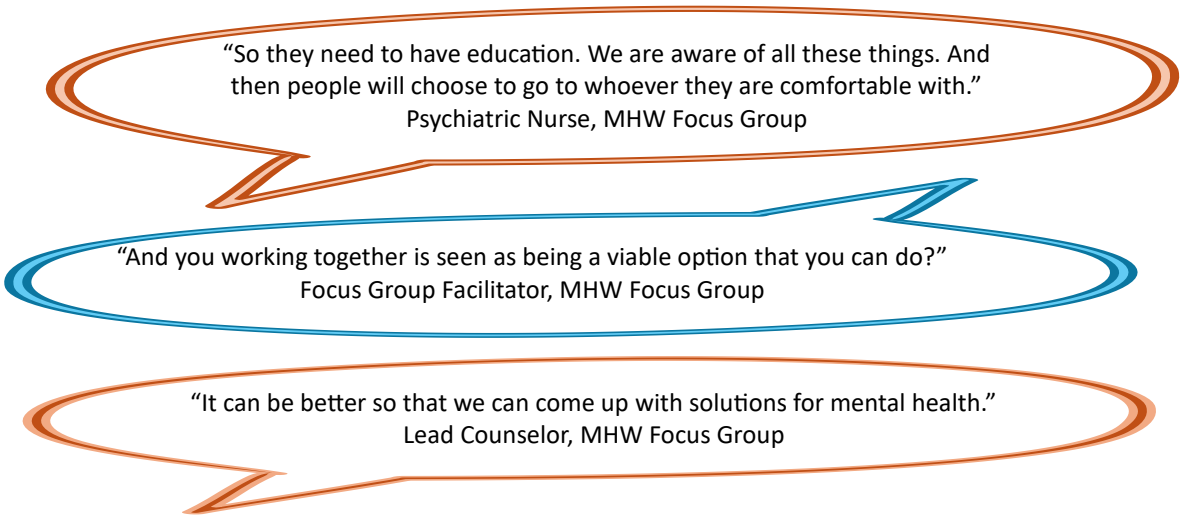
SECTION 7: SYSTEMS AND SERVICES TO SUPPORT MENTAL HEALTH AND CARE IN LESOTHO

Finally, participants were asked about the quality of systems and services devoted to mental health in Lesotho, as well as recommendations for strengthening both.

7.1 Governance and leadership

7.1.1 Local systems

At the local level, participants mentioned that local leaders and partners should be involved in promoting mental health and mental health initiatives. Local chiefs, teachers, traditional health practitioners (THPs), religious leaders, mental health professionals, and community-based organizations (CBOs) were suggested as being able to organize and lead community awareness campaigns, provide mental health training integration at community levels, and provide guidance for community members needing services and caregivers supporting loved ones. An impediment to coordinated leadership initiatives could be systems and institutions working against one another. Some participants felt that there was animosity between professionals like social workers and counselors, or THPs, religious leaders, and health providers, that could preclude their ability to work together. Participants also noted that this was not the case across the entire country, and that where possible conversation between these stakeholders should be initiated, to find common ground:



7.1.2 District systems

District Health Management Teams (DHMTs), district-level government entities (e.g., Ministry of Social Development, Ministry of Local Government, and District Administration) and other stakeholders (e.g., police, community-based organizations) should improve coordination to ensure access to mental health services and support for addressing social determinants of health, including unemployment, poverty, gender-based violence, and community violence.

This lack of coordination and leadership related to social determinants of health can result in a breach of trust of institutions:

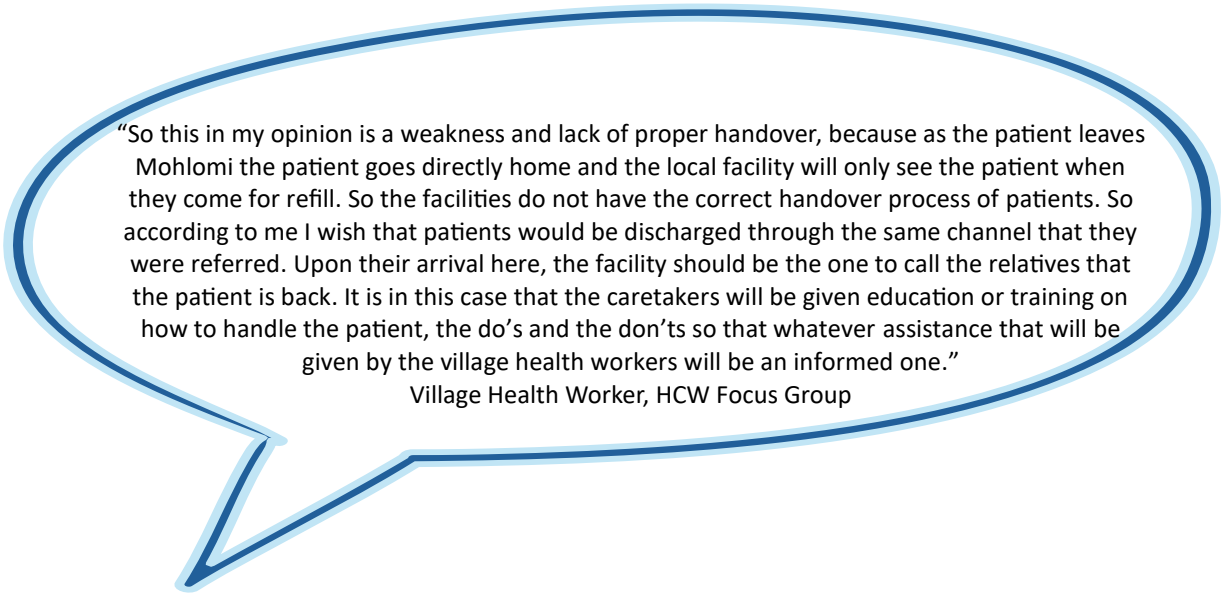
> "That support, we do not find it from the DA's office. The manager of the district is not able to help you. Instead they criticize you."
> Unemployed, Community Focus Group

7.1.3 National systems

Nationally, some participants were distrustful of Parliament and the Ministry of Health. They felt that government officials stigmatized mental health and therefore neglected allocating appropriate funding and resources to supporting mental health care. Additionally, policies, legislation, guidelines, professional licensing, and a strategic plan were either outdated or non-existent, leaving mental health professionals at times unsure how to provide care. Managing patients with physical and mental comorbidities is a challenge in part due to unclear guidelines, for patients at Mohlomi as well as physical health hospitals. Care and wellbeing of patients were understood to be compromised because of a lack of leadership; the forensic unit of Mohlomi Hospital was overcrowded and providers felt that care provision was inconsistent due to a lack of guidelines:

> "I think we have to start with the guidelines and SOP, so that we treat the patient like, we refer to something documented. The problem with us treating the patient with our own understanding – I can maybe suggest a patient with this. The next person thinks the patient needs, discounts my opinions or I didn't even have a chance to express myself, "Maybe I gave this patient this because of that and that." So it impacts the patients' conditions, and I think we fail patients maybe 50% of the time. We make inappropriate kappa wrong diagnosis."
> Psychiatric Nurse, MHW Focus Group

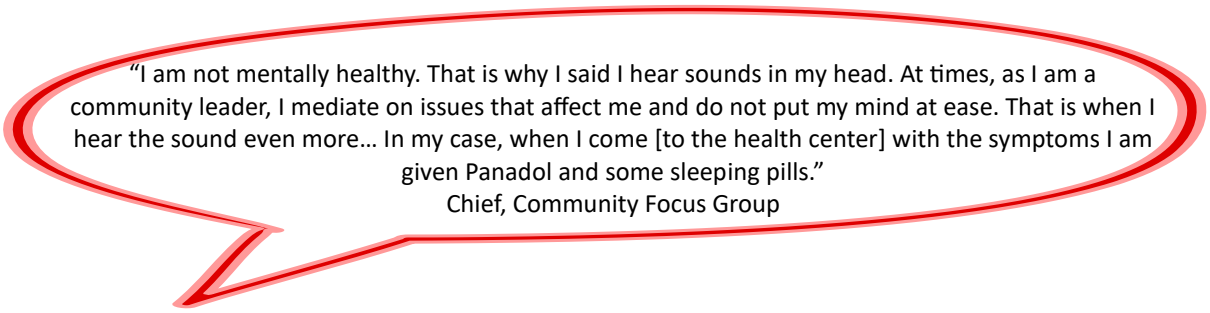
Other participants noted that there were not clear up- and down-referral guidelines, or training for pharmacists as new medications are introduced across the country. This can affect patient recovery and adherence:



7.2 Human resources

7.1.1 Local

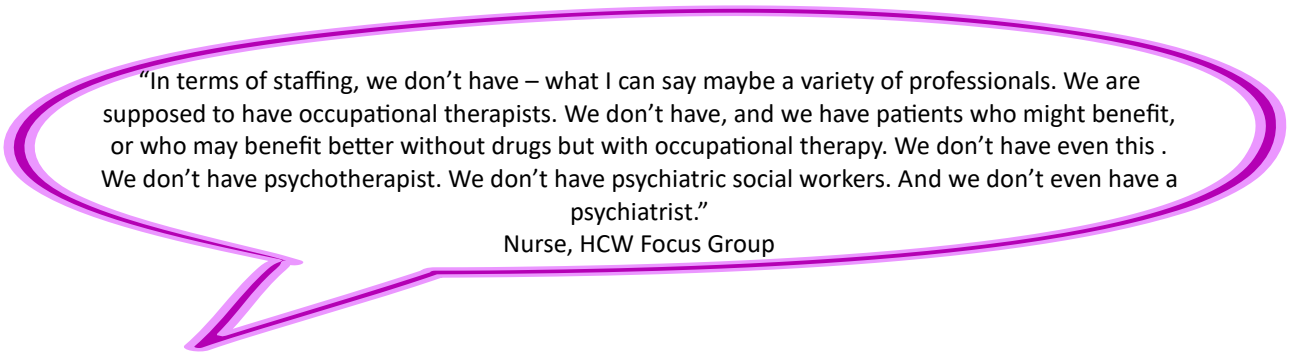
Locally, village health workers are not trained to provide mental health services including referrals. Despite this, when they notice someone being stigmatized in their communities they try to intervene. Additionally, they try to assist patients to the health center for mental health care, though their efforts are hampered by distance and lack of transportation. Additionally, when patients are experiencing psychosis in communities, the VHWs may try to intervene but do not have the training and are at times concerned for their safety. Patient safety can also be compromised, as a lack of skilled professionals in communities can result in patients being restrained. Additionally, a lack of mental health expertise in health centers can compromise patient care, as with one participant who explained being provided with painkillers:



In addition to a lack of training, these challenges are also due in part to a lack of VHWs equal to community populations and health needs, as well as a lack of mental health counselors at health centers.

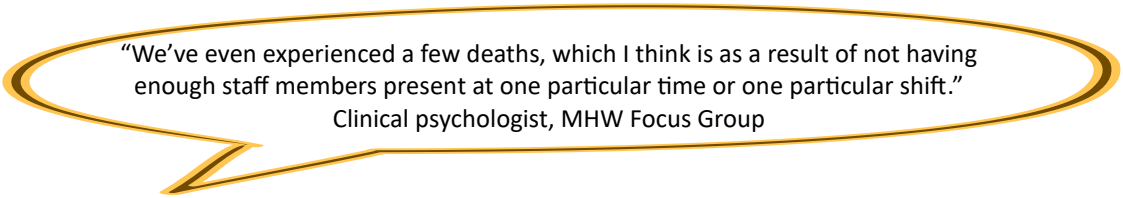
7.1.2 District

At the district level, there are too few psychiatric nurses to provide thorough assessments and care for all patients needing it. Mental health care at district levels is also lacking other experts such as clinical psychologists, social workers, and counselors, who can provide group and individual psychotherapy. Inpatients suffering severe illness, injury, or even amputation do not have access to mental health services, nor do health providers working in these wards. Hospitals also lack occupational therapists to facilitate recovery and skills development. Teams are needed to provide care:



7.1.3 National

Nationally, there is no psychiatrist at Mohlomi Hospital. Additionally, there are no child, adolescent, or geriatric specialist psychiatrists or psychologists and no occupational therapist. Mohlomi also has introduced community services, which has increased demand for mental health services, without a commensurate increase in staffing. Because Lesotho does not have rehabilitation services, patients needing treatment for substance abuse are admitted to Mohlomi, which does not have the expertise or the capacity to provide adequate care. The lack of adequate staffing in number and in specializations puts patients at risk:

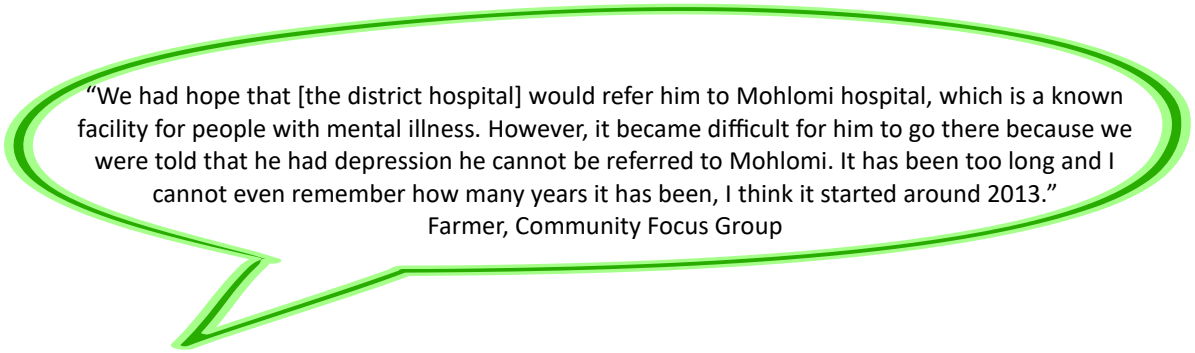


Apart from deaths, participants noted that lack of adequate staffing has also lead to patients escaping and facing threats from the nearby community, and to patients contracting HIV while under care. Finally, these conditions strain the health providers, leading to distress and burnout, with no employee wellness programs or access to an external mental health provider.

7.3 Service delivery

As mentioned above, referral systems between community and national levels of care are not clear and can hinder delivery of quality care. Some participants spoke of being referred to Mohlomi but then being denied care at the hospital without being told why. Another

participant explained that he took his son to a district hospital for mental distress. They were misinformed that the son could not be referred to Mohlomi because the son had depression, and so the son has been unable to receive needed care for years:



Also mentioned above, some participants noted that the mental health care system in Lesotho is currently heavily medication-based and felt that counseling and psychotherapy should be made accessible to patients, as well as medication. Increasing human resources could improve service delivery through the provision of patient-oriented team-based care that included psychiatric nurses, counselors, occupations therapists, and other mental health professionals. Team-based care should also include physical health doctors, as multiple participants described patients with physical and mental comorbidities as being unable to access quality care. Mohlomi, for example, is not equipped to manage physical conditions, and other hospitals are not equipped to manage mental conditions. Health professionals were unclear on how to provide care to patients with comorbid conditions. Additionally, when patients with a known mental illness try to seek care for physical complaints, they can be stigmatized and health workers may dismiss their complaints. Health care workers may also assume that patients presenting with delusions or disorientation are mentally ill, without ruling out physical causes. Team-based care could improve service delivery through improved collaboration between health and mental health professionals.

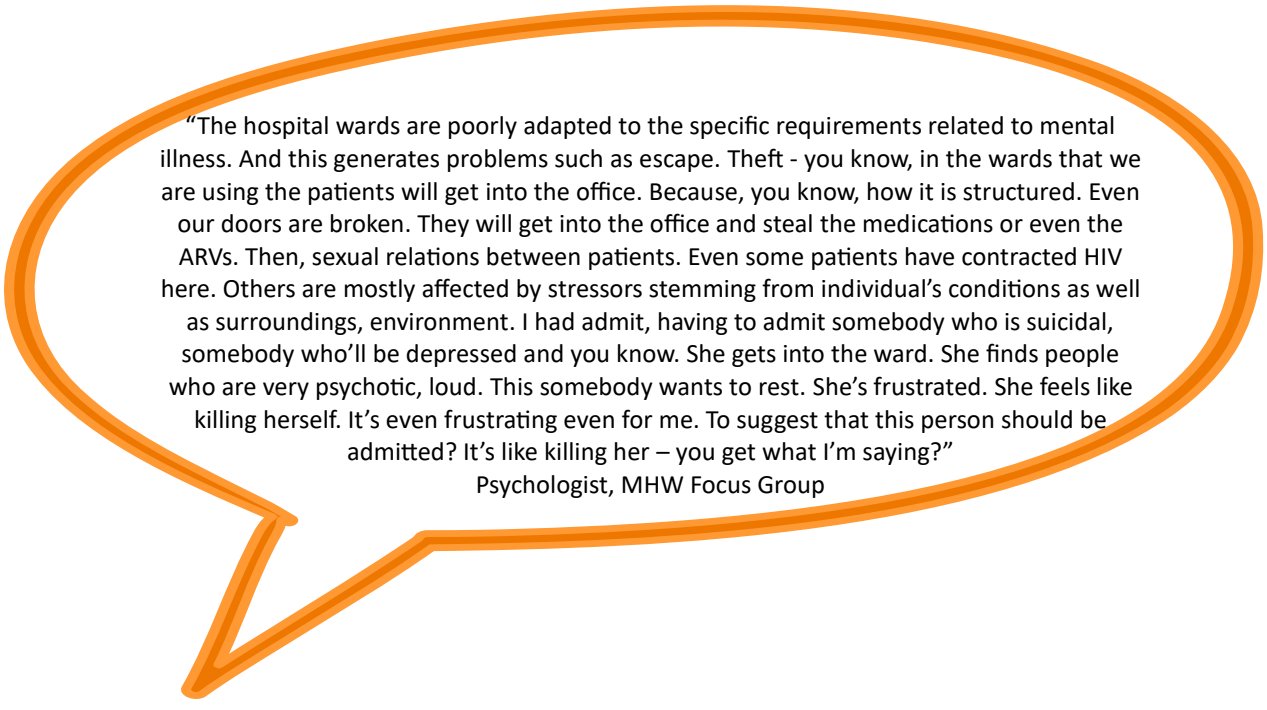
Service delivery may also be compromised due to a lack of continuity of care, and so patients should have access to the same mental health professional consistently over time. Participants also noted the stress that can be placed on caregivers, and so caregivers should be included, with patient permission, in discussions of patient care. Family systems approaches to mental health care should also be introduced at all levels of mental health care, to support patients and caregivers, and to address the issues of family conflict that have been mentioned in previous chapters.

Participants also understood that service delivery was compromised by a lack of professionals. Opportunities should be explored to introduce group therapy and peer support at all levels of care, which would both reduce strain on a resource-limited system and allow patients with common lived experiences to support and learn from one another. Finally, participants described service delivery as being limited due to a lack of inpatient units. MOTU's should be renovated and appropriately staffed to allow inpatient care at the district level.

7.4 Infrastructure, access, and availability

Participants also noted that medication could be difficult to access. Health centers and CHAL hospitals may not stock psychotropic medications. District hospitals may not regularly stock all medications used at Mohlomi, meaning that when a patient is discharged their prescription may be unavailable close to home. Additionally, ongoing training is not available to pharmacists across the country, who may consequently be unfamiliar with newly introduced medications. When stock-outs occur, pharmacists may switch medications without consulting the prescribing doctor. Finally, patients are not always informed of potential side effects of medications. All of these factors can affect service delivery and medication adherence.

Additionally, participants detailed the ways in which Mohlomi is outdated and unconducive to patient care. The hospital is in need of renovations to provide a functioning geyser, heat in the winter and air conditioning in the summer, and updated sewage treatment. The building's architecture is not suitable for all patients. The hospital offers dormitory-style rooms for women and men, with inadequate space, and a lack of privacy. Providers are unable to separate patients who need to be separated. The environment is not conducive to healing, leading to treatment delays. Patient safety is also compromised:



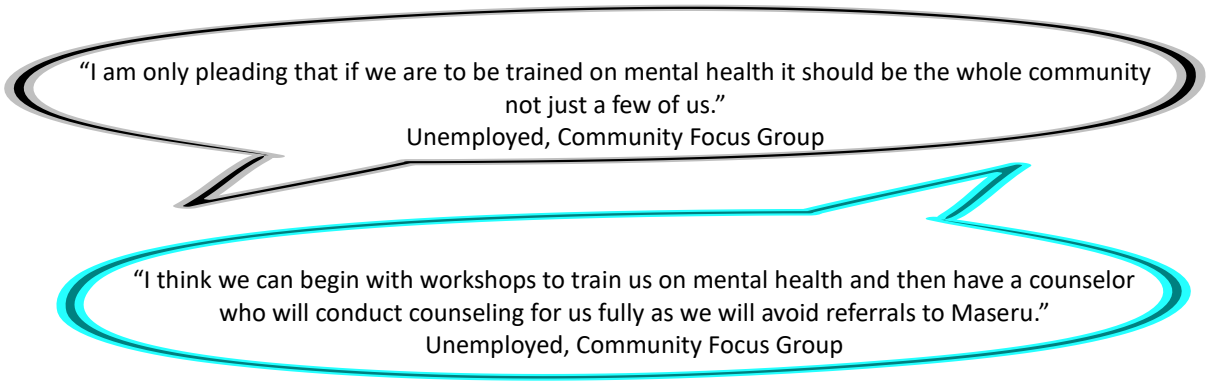
There are not enough beds for patients, and damaged bedding is not replaced. Offices are not secure, leading to theft and possible compromise of patient confidentiality. There is not space to receive visitors, which can again result in a breach of patient privacy. Mohlomi has no system for online meetings or professional development training. Equipment and vehicles are in disrepair, with no funding to replace them. The hospital has shortages of cleaning supplies, lightbulbs, and clothing for patients, due to a prolonged process of procurement

from the MOH. Finally, there are no units to provide care to children, adolescents, and older adults. The hospital needs to be updated to improve patient care.

Additionally, MOTU's are not equipped to provide inpatient care. Patients needing inpatient care must go to Mohlomi, which can be inaccessible due to a lack of transportation. The lack of district inpatient care also further strains Mohlomi's limited resources. Lesotho lacks rehabilitation services, so any patient needing treatment for substance abuse must go to Mohlomi, again straining the hospital's resources. Mohlomi does not have rehabilitation facilities. And patients in communities do not have the option of receiving telehealth, as mental health professionals are not provided with mobile data. MOTU's should be renovated to support inpatient care, and rehabilitation facilities should be established. Psychiatric nurses and other providers should be provided mobile data so that patients in communities can access care. And transportation for patients needing care should be assured across all levels. Additionally, transportation should be readily accessible to allow mental health professionals to facilitate community outreach.

7.5 Information

Participants in this study included providers and recipients. Across all levels, these participants felt they lacked knowledge related to mental health promotion and mental illness prevention. At the tertiary and district levels, mental health workers expressed a need for ongoing professional development. Health care workers also felt they needed more regular training and refreshers. At health centers and in communities, providers were interested in receiving ongoing training to identify, engage with, and refer those needing care. At all levels, a need to reduce stigma was noted. Many participants in Community groups expressed interest in learning more about mental health, even if they had never received services themselves:



In addition to a lack of knowledge and expertise related the mental health field broadly, participants linked a lack of country-specific data to challenges in advocating for increased funding, from government and from international actors. Mental health-related research should be increased, to better understand the needs of the Basotho people and to identify the best practices in providing mental health care in Lesotho. Professional development of relevant stakeholders should include training in grant writing to secure funding. Increased

research should happen in addition to continued training across all levels of care, specialized training across levels of care, and provision of training to mental health-related sectors.

7.6 Financing

To be able to implement the recommendations listed above will require financial support from the government and other sectors. Many participants were skeptical of Parliament and the Ministry of Health's dedication to improving mental health and care in the country. There was a feeling from many participants that mental health was not being prioritized, and that the government preferred allocating funds to physical health care even at the expense of mentally ill patients:

"The problem they have is that for everything to be implemented they need to go through the government. And that on its own is a barrier because they take forever to respond. When you get there and you say, "I want to fund Mohlomi with certain resources," then you have to go to the government. Then the government will allocate those resources via the Ministry of Health, according to where they find the needs are. Even if as a donor you feel like the mental health institution is neglected in Lesotho."

"From time to time there were those good people who would donate some resources [to Mohlomi], some computers, but they get stolen at the ministry headquarters. And they, the bosses there will be saying, "No, leave those mahlanya. We'll attend mentally okay people here in town."
Psychologist, MHW Focus Group

Participants suggested decentralizing procurement so that donations can be made more easily to the mental health sector. Additionally, funding should be allocated and/or increased, to train and retain mental health experts, to increase salaries to be commensurate with regional norms, to improve service delivery, and to ensure appropriate resources are provided throughout the country to support mental health.

7.7 Inclusion of nongovernmental sectors

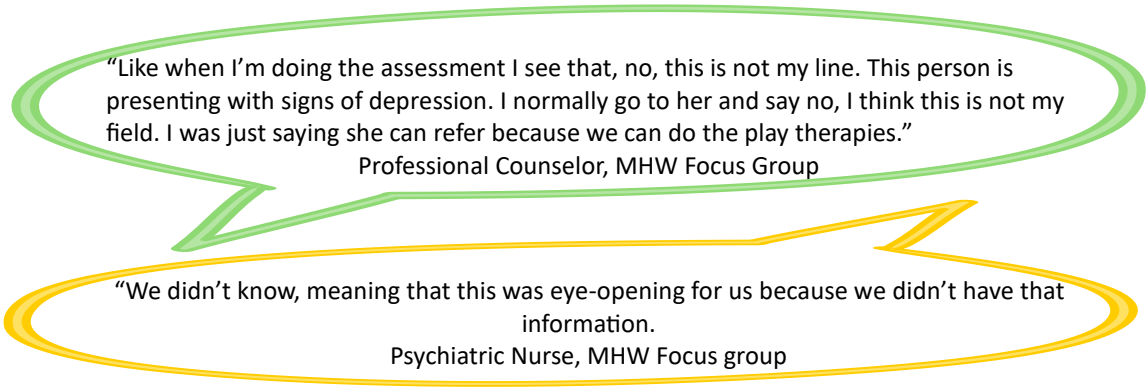
Many NGOs are currently working with the government to improve mental health research and service provision throughout Lesotho. Additionally, Lesotho relies on guidance and support from international entities including the UN, WHO, African CDC, and academic institutions, when developing policy and procuring funding for mental health. While these relationships should be fostered, participants did feel that many local stakeholders are not included in mental health conversations:

"I think a lot of our policy makers only believe things when they come from NGOs."
Medical laboratory technologist, MHW Focus Group

Participants suggested, for example, that the National University of Lesotho (NUL) be included as a stakeholder in future mental health conversations, and that a psychology department be established at the university. Participants also noted multiple mental health advocates and advocacy groups with platforms on social and traditional media and suggested that the ministry engage in conversations with the advocates, to unify mental health related messaging. Locally, trusted leaders and community groups should be part of mental health messaging in communities, to ensure the development of acceptable initiatives and community buy-in. Finally, the voices of people with lived experiences should be heard, and their experiences should inform improvements in care.

7.8 Communication across systems and levels

Threaded throughout the above sections is the need for improved communication across systems, sectors, and levels. Some members of focus groups also that even when they were employed in similar geographical space and working in mental health, they were unaware of one another, emphasizing the need for improved coordination, communication, and collaboration between specialists and across all levels of care:



Lesotho has no local or national directory of mental health resources at different levels of care. An accessible resources database should be developed and regularly updated to include providers, facilities, and links to relevant resources. In addition to a directory, participants noted that referral pathways between service providers (e.g., local leaders, counselors, social development, police) should be clarified. Finally, communication between village health workers and health centers can be limited, meaning that mental health conditions that VHWs are observing in communities are not known to health centers or referred as needed.

7.9 Recommendations

Participants' recommendations across these pillars of health care are summarized in Table 1 below. These recommendations – for policy, personnel, service delivery, infrastructure, information, and financing, as well as for nongovernmental sectors and communication – should be addressed at all levels of care and with the inclusion of all relevant stakeholders.

Summary

- Systems and services for the provision of mental health care exist in Lesotho, but should be strengthened to ensure best practices are being utilized across all levels of care
- Provision of quality care requires increased funding to train and retain personnel, improve infrastructure, and ensure provision of necessary resources
- Provision of mental health education and care should include collaboration between multiple governmental and non-governmental sectors, with clear governance and leadership established
- To improve mental health care, the government must establish clear policy and procedure guidelines that can be followed by care providers and researchers
- Communication, coordination, and collaboration between providers across all levels should be improved to ensure highest quality of care

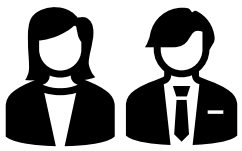
Governance and leadership 	Local/ community 	♟ Explore opportunities for collaboration with local government and other local leaders ♟ Clarify which health center is a patients' primary care facility, in areas where there are multiple facilities ♟ Providing resources to support community-based mental health support	
	District 	♟ Support for addressing social determinants of health, such as community violence and poverty ♟ Collaborate with district government and DHMT to improve access to training and service delivery	
	National 	♟ Increase collaboration between ministries ♟ Clarify standard operating procedures (SOPs) and treatment guidelines ♟ Endorse mental health policy and mental health strategic plan ♟ Clarify policy for managing physical and mental comorbidities ♟ Clarify policy for up- and down-referrals ♟ Increase support from Parliament ♟ Increase mental health budget ♟ Clarify and simplify bureaucracy for providers and providers-in-training to obtain internships in relevant mental health sectors ♟ Increase participation of mental health experts and advocates in conversations related to developing and implementing innovative solutions to mental health promotion and care-related activities ♟ Update monitoring and reporting systems for mental health ♟ Establish a licensing/regulating board for mental health professionals	
Human Resources 	Local/community 	♟ Employ mental health counselors at health centers ♟ Employ additional VHWs and capacitate all VHWs to provide screening psychological first aid, basic mental health support, and referrals	♟ Implement wellness programs across all levels ♟ Ensure debriefing of staff after adverse or traumatic situations ♟ Ensure competitive salaries to attract and retain talent ♟ Increase the number of mental health professionals employed at all levels ♟ Provide risk pay
	District 	♟ Employ clinical psychologists at district hospitals ♟ Employ social workers at hospitals, to provide basic psychotherapy and link patients/clients to services ♟ Employ additional psychiatric nurses and mental health counselors at hospitals, to facilitate thorough clinical assessments and outreach ♟ Employ an occupational therapist at each hospital ♟ Employ mental health counselors for patients within hospital wards	
	National 	♟ Employ a psychiatrist at Mohlomi ♟ Employ specialized psychologists and psychiatrists (e.g., forensic specialist, child and adolescent specialists, geriatric psychiatrist) ♟ Employ mental health professionals for palliative care ♟ Employ and occupational therapist at Mohlomi	

Table 1: Recommendations for improving systems and services for mental health services

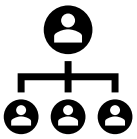
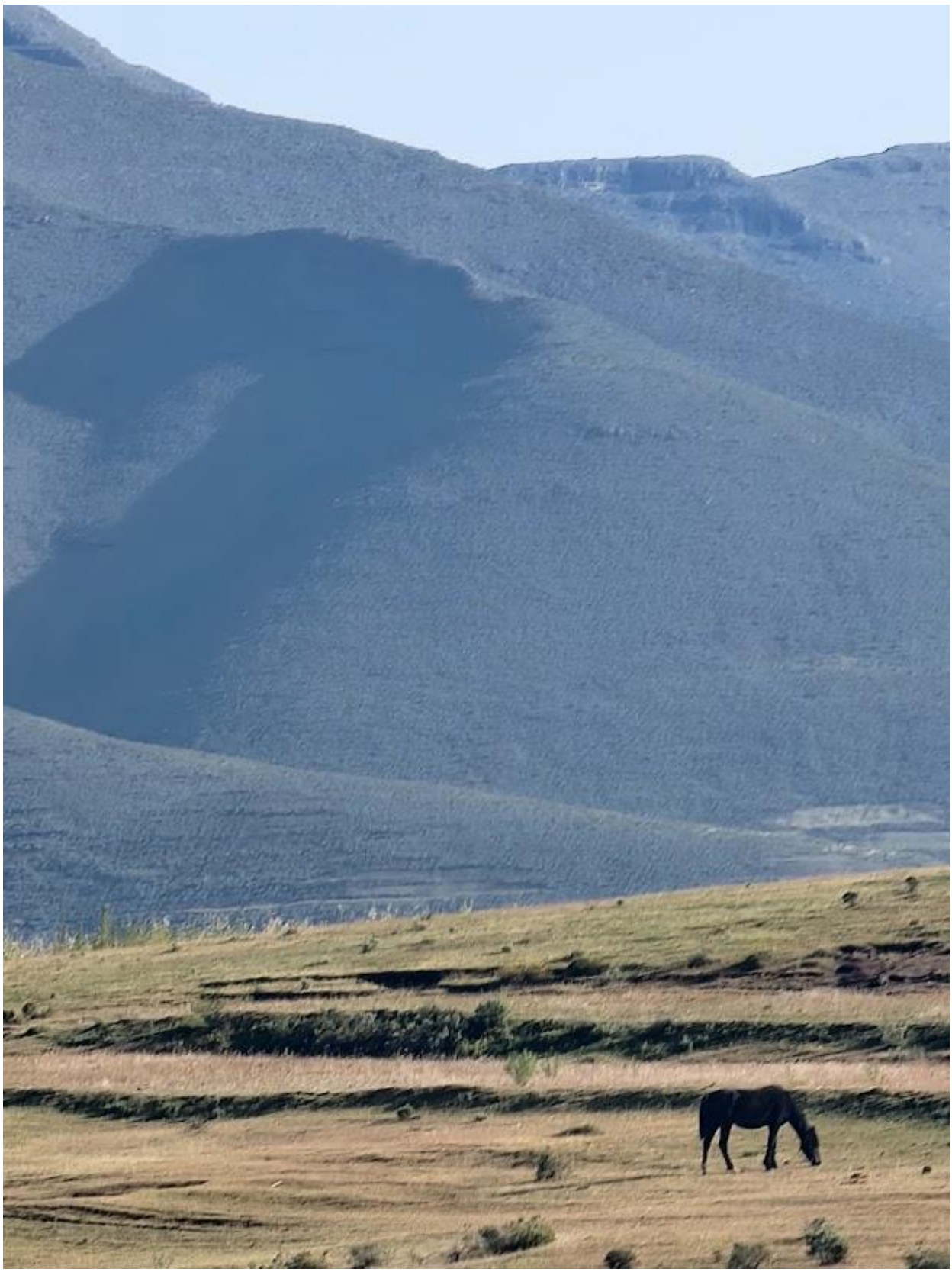
Service delivery 	♟ Ensure effective communication with patients/clients, for appropriate referrals ♟ Ensure access to counseling and psychotherapy at all levels of care ♟ Provide access to patient-oriented team-based care, as well as family systems services ♟ Include, if relevant, of caregivers in service delivery and mental health care ♟ Provide continuity of mental health care ♟ Provide inpatient mental health services at the district level ♟ Initiate peer support groups within communities, health centers, and hospitals
Infrastructure and access 	♟ Ensure access to medication at all health centers and hospitals ♟ Decentralize procurement to facilitate Mohlomi's access to needed resources ♟ Ensure transportation for patients to access care across all levels ♟ Ensure transportation for psychiatric nurses and other experts to provide outreach services ♟ Facilitate mobile data so that mental health professionals can provide telehealth ♟ Establish regional rehabilitation centers ♟ Renovate Mohlomi and MOTUs to ensure hospitable, confidential, and safe spaces to receive care ♟ Develop child and geriatric units at Mohlomi
Information 	♟ Continued training and professional development across all levels of care ♟ Specialized training across all levels of care ♟ Training targeted to allied (e.g., police) and health professional (e.g., pharmacist) sectors ♟ Providing stigma reduction training for health and other providers ♟ Increase support for mental health-related research in Lesotho
Financing 	♟ Increase allocation of funding for training and retaining mental health experts ♟ Increase allocation of funding to improve mental health service delivery throughout the country ♟ Increase allocation of funding for the provision of appropriate resources to improve mental health care, across the country ♟ Increase salaries of mental health experts to reflect regional norms
Nongovernmental sectors 	♟ Include trusted local leaders (e.g., traditional health practitioners, religious leaders, chiefs) and institutions in mental health conversations ♟ Utilize local support groups, women's groups, and sports groups to facilitate mental health promotion messaging ♟ Collaborate with NGO's to improve service provision and research ♟ Collaborate with advocacy groups to develop common messaging around mental health and care ♟ Establish a Department of Psychology at NUL ♟ Include international entities and expertise in development of best practices (e.g., CDC Africa, UN, WHO
Communication 	♟ Improve relationships, communication, and collaboration between specialists and across levels ♟ Develop an accessible directory of mental health resources at different levels of care, including providers, facilities, and links to relevant resources (e.g., Africa CDC, Lesotho mental health SOPs) ♟ Establish clear referral systems and pathways for integrating care between service providers (e.g., local leaders, counselors, psychiatric nurses, social development, police, occupational therapists)

Table 1: Recommendations for improving systems and services for mental health services (continued)

SECTION 8: WHERE DO WE GO FROM HERE: NEXT STEPS IN IMPROVING MENTAL HEALTH AND CARE IN LESOTHO



8.1 Summary

The preceding chapters provide findings from a situational analysis and needs assessment of mental health in Lesotho, from the perspective of health workers, mental health workers, and community members. These findings have highlighted the intersecting adversities and resilience resources experienced by people in Lesotho across the lifespan. The findings also provide directions for improving mental health and the mental health infrastructure in Lesotho. While the preceding chapters have addressed mental health in early childhood, adolescence and youth, adulthood, and older adulthood, as well as the systems and services related to mental health care provision, this final chapter will explore how lifespan development and mental health systems interact, and how that interaction also provides direction for improving care in resource-limited settings.

8.2 Taking a lifespan multilevel social-ecological approach to mental health in Lesotho

While the preceding chapters separated mental health and care by developmental stages, this chapter will explore mental health in Lesotho across the lifespan and within systems, highlighting the need for mental health care to begin early in life and span beyond just the health system.

A lifespan social-ecological approach to mental health care embraces a holistic perspective to understand and explore how people develop across the lifespan[50] (Figure 15). This approach recognizes that each developmental stage builds on previous stages, so that experiences from preconception onward influence a person's current emotions, feelings, and behaviors. These experiences include relationships and contexts, and the interaction between relationships, contexts, and physiology.

8.2.1 Mental health across the lifespan

Biological sensitivity to context and conditional adaptation

Biological sensitivity to context suggests that individuals are more or less sensitive to environmental factors, based on their genetics and physiology. Additionally, from an evolutionary perspective, epigenetics and brain plasticity (discussed below) can be considered as conditional adaptations made in response to contexts like social and physical environments, that result in differing developmental trajectories[51]. Thus, a person's mental and physical development are influenced by their surroundings[52]. From this perspective, behaviors that have historically been viewed as pathological can be reframed as adaptations to one context that are perhaps less adaptive in other contexts.

[50] Hunt X, Skeen S, Honikman S, Bantjes J, Mabaso K, Docrat S, Tomlinson M. Maternal, child and adolescent mental health: An ecological life course perspective. South African child gauge. 2019;2019:131-44.
[51] Del Giudice M, Ellis BJ, Shirtcliff EA. The adaptive calibration model of stress responsivity. Neuroscience & biobehavioral reviews. 2011 Jun 1;35(7):1562-92.
[52] Porges SW. Polyvagal theory: A science of safety. Frontiers in integrative neuroscience. 2022 May 10;16:871227.

Epigenetics

Epigenetics describes the influence of the environment on genetic expression. Early environments in childhood – including relationships with caregivers and other people – influence whether or not genes are turned on, meaning that the safety and security of the environments in which children live can have lasting biological impacts. Growing up with greater adversity, for example abuse or disorganized attachment from a young age, can increase the likelihood of developing depression or attempting suicide. These effects are also not limited to childhood, and adversities throughout life can affect gene expression and subsequent vulnerability to mental distress.

Plasticity

Brain plasticity describes how the brain develops and adapts throughout the lifespan[53]. Plasticity decreases with age, and the ability of the brain to adapt is highest in childhood and into early adulthood. Early life experiences can therefore affect how the brain develops neural connections and functions, affecting patterns of development throughout childhood. For example, early adversity can increase the sensitivity of the brain to stress, decrease a person's ability to regulate emotions, and even affect memory and other executive functioning.

Cascading

Development cascading is the process by which current functioning is influenced by previous experiences, across domains[54,55]. For example, limited socioemotional development in earlier years may affect an individual's ability to develop healthy relationships, but could also lead to challenges in learning or maintaining employment, because of limited focus and social competence. This could influence interpersonal communication, violence, and poverty as people grow into adulthood.

Cumulative stress

Finally, experiencing one adversity can increase vulnerability to additional adversities, meaning that people often experience cumulative or continued stress[56]. Exposure to increased stressors – either in duration or number of individual adversities – increases allostatic load, and the risk of experiencing one or more negative physical or mental health outcomes. Within Lesotho, this could include adversities such as chronic poverty, substance use, and exposure to violence, which can lead to mental health challenges. When experienced in childhood, adversity can impact health in adulthood. Childhood adversity has been associated with negative physical health outcomes (e.g., increased blood pressure,

[53] Stiles J, Jernigan TL. The basics of brain development. Neuropsychology review. 2010 Dec;20(4):327-48.
[54] Masten AS. Resilience in developmental systems. Multisystemic resilience. 2021 Feb 15:113-34.
[55] Russotti J, Warmingham JM, Handley ED, Rogosch FA, Cicchetti D. Child maltreatment: an intergenerational cascades model of risk processes potentiating child psychopathology. Child Abuse & Neglect. 2021 Feb 1;112:104829.
[56] Eagle G, Kaminer D. Continuous traumatic stress: Expanding the lexicon of traumatic stress. Peace and Conflict: Journal of Peace Psychology. 2013 May;19(2):85.

atherosclerosis, diabetes, poor immune suppression) and mental health outcomes (e.g., depression, suicide) in adulthood.

8.2.2 Mental health and social-ecological systems

Mental health throughout the lifespan is impacted by the social-ecological systems in which a person is embedded[57]. Mental wellbeing is influenced not just by biology, but by the interacting systems in which people develop, work, and live. Because of this, mental health and care is not solely an issue for health systems, but for the other systems in which people find themselves.

Human systems

People live their lives within family, friend, and community groups, and individuals within these systems influence one another directly and indirectly. The systems also influence one another. For example, secure attachment of an infant to a primary caregiver promotes positive development in early childhood and can also affect the wellbeing of the caregiver. There is also evidence that even if a primary caregiver is unwell, support from a secondary caregiver such as a sibling or a spouse, can support positive infant development[58]. Additionally, inter-partner conflict and spousal abuse directly affect the mental health of the partners but can also worsen mental health and development of children in the home[22]. Parental migration, common in Lesotho, can affect multiple generations, as grandparents (particularly grandmothers) are caring for grandchildren while parents are away for extended periods. Family systems extend beyond an individual or interpersonal relationship. Therefore, tending to the wellbeing of entire families can benefit more people at once, an added benefit in a resource limited setting.

In addition to the complexity of interactions between generations, there is growing research on the impact of transgenerational trauma on an individual[22]. Psychological trauma can alter genetic expression, which can be passed down to children, leaving the children more susceptible to mental and physical health challenges. Additionally, psychological trauma can affect interpersonal interactions, including attitudes and beliefs, personal behaviors, relationship skills, and communication, all of which can affect parenting. Changes in interactions between a parent and a child can therefore affect child development (see the lifespan section above) and even be transmitted to the child's children as well. Psychological trauma leading to transgenerational trauma can result from individual experiences of abuse or childhood adversity, but can also be caused by external forces including community violence, colonialism, systemic prejudice, and national and international traumas like the HIV epidemic and COVID-19 pandemic. Given the adversities noted within this study, it is likely that transgenerational trauma plays a role in mental wellbeing in Lesotho, though this is currently an under researched topic.

[57] Bronfenbrenner U. Contexts of child rearing: Problems and prospects. American psychologist. 1979 Oct;34(10):844.

[58] Stevenson A. Child and adolescent development: an expanded focus on public health in Africa. Juta and Company Ltd; 2018 Apr 16.

In addition to families, community systems influence mental wellbeing. Multiple participants noted community violence as an adversity within their communities, which breeds fear and anger and disrupts service provision. For children and adolescents, bullying at school is a challenge. These adversities therefore affect individuals but could be addressed through broader universal community initiatives to decrease gang activities, improve employment opportunities, facilitate anti-bullying campaigns, and facilitate place-making for community cohesion. Early intervention to improve employment and raise awareness about bullying could even prevent these adversities before they begin. As wellbeing promotion and prevention are the most cost-effective initiatives related to mental health, universal community initiatives could hold promise for resource-limited settings in Lesotho.

Government and other systems

In addition to human systems are government and non-governmental systems. Many of the adversities and resources identified in this study are affected by these systems. Poverty and employment, for example, were identified in every focus group as adversities throughout the lifespan, affecting children through household poverty and interpersonal relationships, adults through individual poverty and a sense of contribution to community, and older adults through the ability to access needed resources. Economic systems therefore influence every stage of development. Poverty can worsen mental health through increased disparity and isolation from peers, increased stress, and lack of access to resources. In the reverse direction, mental health challenges can increase work discrimination, and some participants have even noted that people in Lesotho have lost employment if their mental health status has been exposed. Loss of employment can also decrease access to mental health care if a person does not have access to transportation. This can create a feedback loop in which poor mental health and poverty influence one another, worsening conditions for an individual, which could spiral to that individual's family and lead to transgenerational trauma. Strengthening economic systems, creating employment opportunities, and developing and enforcing anti-discrimination workplace policies could help to curtail mental distress to individuals, with implications for families and across generations.

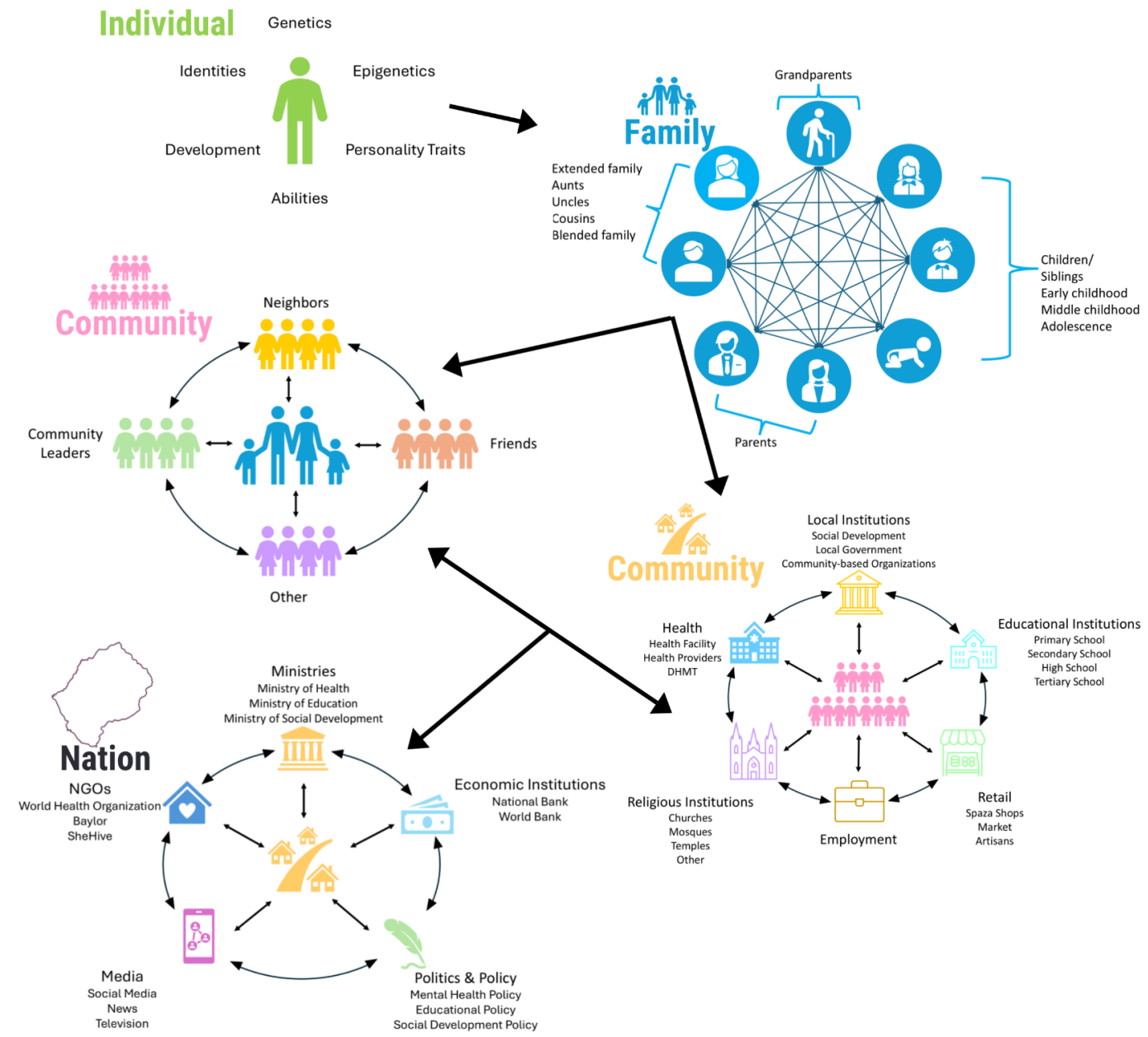
Another system influencing mental health across the lifespan is the health system. As has been mentioned above, mental health care should be integrated into primary health care and include mental health education and promotion from preconception throughout the lifespan. Though health promotion and prevention are the most cost-effective initiatives to address mental health and promote subjective wellbeing across the lifespan, there is no universal solution to mental wellbeing. Mental health education and promotion should be supported through key stages across the lifespan, as the needs of individuals change from childhood through adolescence, and into adulthood and older adulthood. Additionally, supports must be available and accessible for early intervention, treatment, and recovery for those who need it. Targeted and treatment approaches should be developed for specific diagnoses, with medication and psychotherapy provided for all who need it. This requires additional investment into mental health care, as discussed above.

Promotion, prevention, and early intervention can also be incorporated into educational systems in childhood and the workplace in adulthood. Mental health education should be

included as life skills development from day care and preschool onward, to provide the most positive contexts possible for healthy development. Mental health education in schools can include socioemotional development in younger years, and relationship building, problem solving, and sexual and reproductive health in adolescence. Within the workplace, antidiscrimination policies that include disability, gender, sexual orientation, and other discrimination, could prevent marginalization or loss of employment. Workplace wellness initiatives could help prevent burnout and retain talent, improving the economic sector while improving wellbeing. Again, these initiatives affect the lifespan, as children's experiences at school influence their experiences at home and vice versa. Additionally, work stress can influence caregiver-child and spousal relationships at home, thereby affecting the caregiver, spouse, and child development.

Lastly, international influences on mental health are understudied, but some participants did suggest a connection between social media and suicide. Some adolescents in Lesotho post suicidal ideation on social media platforms prior to attempting suicide, and these posts are often unnoticed until after attempts are made. Social media presents challenges and opportunities. There is some evidence that external influences like social media and globalization are increasing the divide between generations, worsening mental health and contributing to suicide behaviors[59]. Social media can also be a space for advocacy, and future research should explore how social media might be used within Lesotho as a space for individuals who need care to find positive resources and supports.

[59] Imberton G. Chol understandings of suicide and human agency. Culture, medicine, and psychiatry. 2012 Jun;36:245-63.



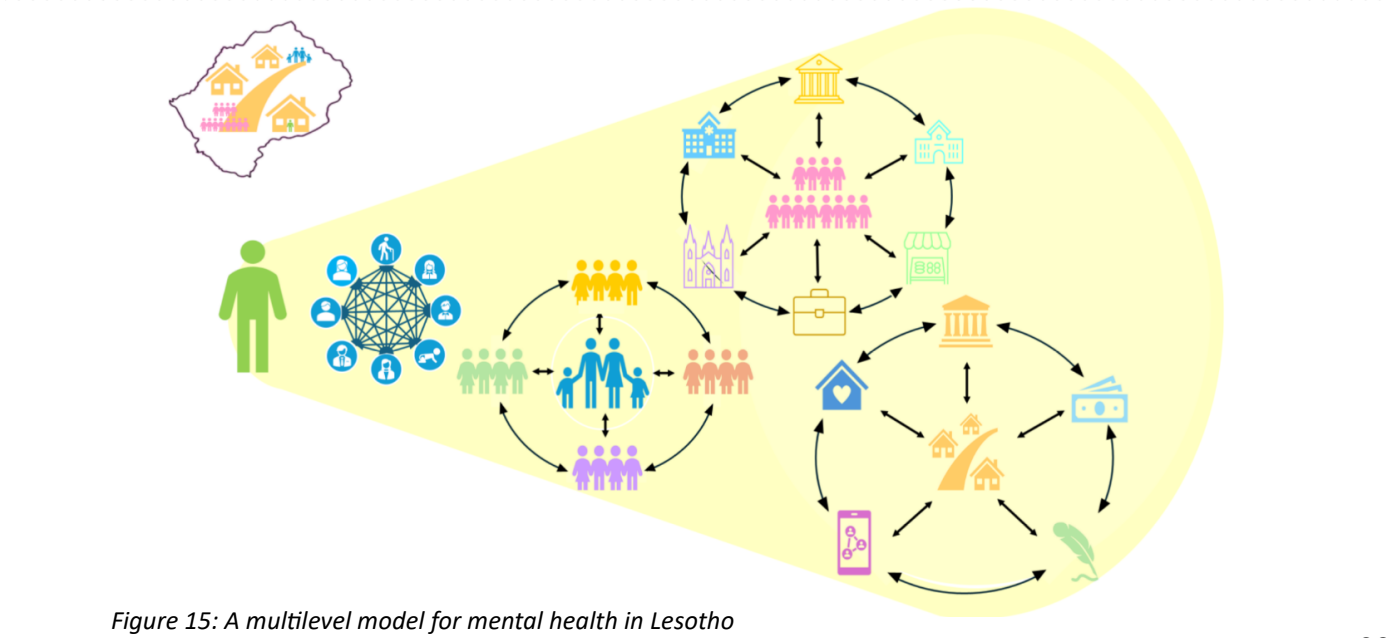


Figure 15: A multilevel model for mental health in Lesotho

8.3 Study strengths and limitations

While these findings suggest multiple avenues for supporting mental health across the lifespan and social-ecological systems, there are limitations to this study. While efforts were made to ensure a heterogeneous sample providing diverse perspectives from across the country, participants were recruited by convenience sampling and with the assistance of local leaders; their perspectives may not be fully representative. This study was qualitative and so while suggesting directions for future initiatives and study, it may not be generalizable. Additionally, national leaders were not engaged as part of this study. While focus groups were held in private and participants were asked not to share the discussion afterwards, confidentiality could not be guaranteed; some participants may consequently have felt uncomfortable speaking honestly. Finally, the scope of the full study was to obtain a broad overview of the mental health landscape in the country, and practicalities of time limited the depth with which any theme could be explored.

8.4 Conclusion

Despite these limitations, this study presents the voices of communities and the health and mental health workforce across Lesotho, thereby engaging key stakeholders and providing an important step in directing future mental health initiatives and research.